

BOON OR BANE? EXAMINING THE VALUE OF LONG-TERM CARE INSURANCE

HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED ELEVENTH CONGRESS FIRST SESSION

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BOON OR BANE EXAMINING THE VALUE OF LONG-TERM CARE INSURANCE

WEDNESDAY, JUNE 3, 2009

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2 p.m. in room SH-216, Hart Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senators Kohl [presiding], and Martinez.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. Good afternoon, and we thank you all for being with us today.

In March, this committee heard from experts, including Senator Kennedy, who all agree that reforming our long-term care system is a necessary part of reforming the entire healthcare system.

With America aging at an unprecedented rate, and with the high and rising costs of caring for a loved one, the financing of long-term care must be addressed if we are going to get healthcare costs under control.

Today we're going to examine one way families can finance their long-term care costs, namely through long-term care insurance. We all know that long-term care is expensive, with the cost of an average nursing home now nearly \$70,000 a year.

However, according to the Congressional Research Service, most Americans do not realize that Medicare offers only limited home health services, and Medicaid will not cover long-term care costs unless household savings are nearly entirely depleted.

States share the responsibility of providing Medicaid funding for long-term care with the Federal Government and are also looking for ways to reduce their expenses. As of today, 43 States are in the process of launching Partnership programs which provide incentives to consumers who purchase private long-term care insurance.

But in the rush to ease the burden of long-term care costs on State budgets, we fear that some key concerns are being overlooked. We have a duty to make sure that these policies—which may span decades—are financially viable. Several long-term care insurance providers have applied for TARP funds in recent months, raising questions about their solvency.

In addition, many insurance companies have been raising their policyholders' monthly premiums, which can be devastating for older persons who are living on fixed incomes.

The committee is aware of instances in which Americans living on modest, or fixed, incomes who have held policies for many years, have seen premium rates double when a company encounters financial difficulties. For such consumers, the choices are stark, and very limited. They can either dig deeper, and pay the increased premiums, or let their policy lapse, leaving them with no coverage if they ever need care.

Last year I was joined by several Senate and House colleagues in releasing a GAO report on whether adequate consumer protections are in place for those who purchase long-term care insurance. The report found that rate increases are common throughout the industry, and that consumer protections are not even.

While some States have adopted requirements that keep rates relatively stable, some have not; leaving consumers—in many cases—unprotected. This afternoon, we will discuss how we can best protect these policyholders. We need to ensure that premium increases are kept to a minimum, insurance agents receive adequate training, and complaints and appeals are addressed in a timely manner.

We should also make it easier for consumers to accurately compare policies from different insurance carriers, particularly with regard to what benefits are covered, and whether the plan offers inflation protection. States should also have to approve materials used to market Partnership policies.

Today I will introduce, with Senator Wyden, the Confidence in Long-Term Care Insurance Act of 2009, which calls for many of these improvements. It's estimated that two out of three Americans who reach the age of 65 will need some long-term care services and support at some point to assist with day-to-day activities, and which can enable them to maintain a high-quality and independent life.

Long-term care insurance is an appropriate product for many who wish to plan for a secure retirement. But until we can guarantee that consumers have adequate information and protections, and ensure that premiums will not skyrocket down the road, long-term care insurance is not ready to be a major part of the healthcare reform solution.

So, we thank all of today's witnesses to being here.

We look forward to your testimony, and we now turn to the ranking member for his comments.

Senator Martinez.

OPENING STATEMENT OF SENATOR MEL MARTINEZ, RANKING MEMBER

Senator MARTINEZ. Mr. Chairman, thank you very much, and good afternoon to you, and I want to thank all of the panel members for being here with us today.

Of many factors that Americans consider when planning their personal and financial future—their income, health, housing security, leisure time and emergencies—the one factor that's often overlooked is the plan for long-term care.

Currently the number of seniors requiring long-term care is on the rise. The Department of Health and Human Services estimates that today about 9 million men and women over the age of 65 are

in need of long-term care. By 2020, that number will be close to 12 million, underscoring the need for more personal and public resources dedicated to providing seniors with long-term care options.

The common barrier is cost. In Florida, for example, a private room in a nursing home costs more than \$70,000 per year, and a home health aide costs more than \$40,000 per year. These expenses could cause a person to quickly deplete their finances, and become dependent on Medicaid.

Many seniors rely on family for their care. Oftentimes these caregivers are baby boomers, including those with children, who have been hit hard by recession. As a result, it has become increasingly difficult for them to afford the expenses associated with providing care.

Many are surprised to learn that Medicare only pays for very limited long-term care services. Medicaid is the largest source of public financing for long-term care. But with family and public funding sources stretched, due to the economic downturn, Congress must look to other options.

Personal planning, like purchasing long-term care insurance policies, offers a viable way to save seniors' assets and reduce the burden on States and the Federal Government.

Presently, only about 10 percent of seniors have chosen to purchase this kind of financial backstop. To encourage more Americans to purchase long-term care insurance, the Federal Government—in 1996—joined States in the Long-Term Planning Partnership Program. The program offers enhanced long-term care insurance products in conjunction with Medicaid as a form of re-insurance. This approach offers protection for consumers, while also saving the State money. This model is promising, and may become an integral part of building our nation's long-term care system.

But the Partnership Program in long-term care insurance, in general, is a relatively recent innovation, and it's still virtually unknown to most Americans.

But as this industry continues to evolve, States should determine whether private long-term care insurance is sufficient to help each individual afford long-term care. State insurance commissioners are in an important position to protect policyholders, and make sure premiums are fair, and will translate into future benefits. In my view, this is an issue that should continue to be addressed at the State level.

Today we'll be hearing from our panelists on the benefits and challenges facing long-term care insurance policyholders, and providers.

So, I look forward to hearing the testimony from all of the witnesses, Mr. Chairman. I thank you for calling this hearing and very timely issue.

I also should let you know that I have a second hearing that's started in about—or will start—in a few minutes, so I may have to excuse myself at some point, but it's very good to see all of you, and thank you for being here.

The CHAIRMAN. Thank you very much, Senator Martinez.

I will introduce our witnesses today. First we will be hearing from Dr. Diane Rowland. She's the Executive Vice President of the

Kaiser Family Foundation, and the Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

Dr. Rowland is also an adjunct professor in the Department of Health Policy and Management at Johns Hopkins University's School of Public Health. She is a noted authority on health policy, Medicare and Medicaid, and health care for poor and disadvantaged populations.

Next we will be hearing from Sean Dilweg, the Insurance Commissioner for the State of Wisconsin.

Commissioner Dilweg is also an active member of the National Association of Insurance Commissioners, where he is chair of their Consumer Affairs Committee, and Senior Issues Task Force.

Prior to this appointment as Insurance Commissioner, Mr. Dilweg served as the Executive Assistant to the Secretary of the Wisconsin Department of Administration. We welcome you here today, sir.

Our third witness will be Carol Cutter, the Chief Deputy Commissioner of the Indiana Insurance Department.

In that role, she oversees the Indiana Long Term Care Partnership Program, the Indiana CHP program for Medicare recipients, the Indiana small employer voluntary reinsurance pool program, the mandate benefit task force. Prior to joining the Indiana Insurance Department, Ms. Cutter spent 30 years in the insurance industry.

Our fourth witness today will be Thomas Stinson, the President of the Insurance Products Retirement and Protection for Genworth, the nation's largest provider of long-term care insurance policies. He is responsible for product development and the management of Genworth's life, long-term care, and annuity products.

Mr. Stinson previously served as President of Genworth's long-term care business, and as President of GE Financial's Personal Financial Services organization. He currently serves on the Board of America's Health Insurance Plans, and the National Commission for Quality Long-Term Care.

Finally, we'll be hearing from Bonnie Burns, the training and policy specialist for California Health Advocates. She has more than 25 years of experience in Medicare, Medicaid Supplement Insurance, and long-term care insurance. She has served as a consumer representative with the National Association of Insurance Commissioners. In addition, Ms. Burns has served on Advisory Committees of the California Department of Aging, Department of Insurance, as well as the several advocacy organizations that address long-term care insurance issues. We welcome you here today.

We'll delighted to take your testimony, and we'll start with you, Diane Rowland.

**STATEMENT OF DIANE ROWLAND, SC.D., EXECUTIVE VICE
PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION, EXEC-
UTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND
THE UNINSURED, WASHINGTON, DC**

Dr. ROWLAND. Thank you, Chairman Kohl, and Senator Martinez, for this opportunity to be with you today to participate in this hearing on long-term care. My testimony today will focus on how our nation currently finances long-term care services, and the key challenges to building a broader role for private health insurance in that market.

I think it's particularly important to note that over 10 million Americans, or almost 5 percent of our adult population, need long-term care services and supports to assist them in their daily activities.

Although the majority of the individuals who receive long-term care services are aged 65 and above—and I know that is the focus of this Special Committee on Aging—42 percent of the individuals needing long-term care are people with disabilities and chronic illness under age 65. I think we need to bear that in mind as we look for solutions, since they are so much a part of our long-term care challenge.

Many people who need long-term care rely primarily on unpaid help from family and friends in the community, but paying for long-term care services is expensive, and can quickly exhaust lifetime savings, especially if institutional care is required. With nursing home care averaging \$70,000 a year, assisted living facilities averaging \$36,000 per year, and home health services averaging \$29 per hour, very few people can afford these services for very long. The cost of these services often exceeds individuals' ability to pay for their care.

While most long-term care services and support, including extended stays in nursing home, are not covered—as you've noted—by Medicare, few people have private health insurance to help pay for their nursing home stays.

Medicare does, in fact, help to fill the gaps for many of the elderly and people with disabilities who need long-term care, but as we all know, to qualify for assistance, individuals must have limited income, and meet stringent assets tests.

Unlike insurance for healthcare services, private insurance for long-term care is still a very limited option for financing care. Private long-term care insurance is primarily offered through the individual market, and has been offered only as a limited part of employer-sponsored insurance. When it has been offered by employees, the take-up rates have been exceedingly low.

Insurance carriers say they have sold about 10 million long-term care insurance policies since 1987. Of the 6 to 7 million of these that remain current, the industry sold about 4 million through individual agents, and slightly more than 2 million through employers or group coverage—quite a different picture than that within our healthcare system.

In assessing the potential, therefore, for broader application of private long-term care insurance in the financing mix for long-term care, it is important to highlight questions such as, how adequate is the coverage from these policies? How well does the market

work? What protections are in place for consumers, and what transparency is offered?

We have reviewed many of these questions and challenges around coverage and financing of long-term care in a report which we released today, and have included with our testimony, called Closing the Long-Term Care Funding Gap, the Challenge of Private Long-Term Care Insurance, and we've submitted that for the record.

Our principal findings in this report continue to focus on key challenges as we move forward to try and broaden this market.

One, cost is a significant barrier for expanding the role of private long term care insurance. Many who will ultimately need long-term care insurance don't have the resources to pay the premiums, especially over a lifetime.

Health risks can deny consumers the coverage that they need. Before purchasing insurance, most consumers must undergo a detailed health screening and evaluation to determine their insurability and risk rating. For people with disabilities, this makes this coverage out of the question.

Buyers also face very complex product design issues that are very difficult for them to fathom and to make realistic judgments about where they ought to be getting their care, or how. So, broader transparency and more help in figuring out the differences between policies and the pros and cons for individuals are required.

A significant problem is the time lag between the purchase and use of benefits, and the kind of coverage that people are picking when they would be signing up for the coverage. So, we really need to look at how to make good decisions 20 to 30 years before the purchased insurance product is used.

Finally, we don't have much of an employer-based market, here, although that offers promise. As we look at employer-based coverage for health insurance being scaled back and as we look at the erosion of retiree benefits, we have some real challenges in trying to build more of such coverage into the employer-based market.

So, as the Nation faces a growing elderly population, the potential for substantial increase in people in need of assistance with long-term care, it is important that we move now to address how to structure and pay for the long-term care services that will be required.

If long-term care insurance is to become more available and utilized, the limitations of the current private long-term care insurance market should be examined and addressed as part of creating a broader market.

Many of the concerns that have led to the current health reform efforts, focusing on the need for regulation and changes in the individual health insurance market, apply equally to the current long-term care insurance market—most notably its high administrative costs, unaffordable premiums, exclusions based on health status, its complexity and lack of comparability across plans.

With revisions to these plans, private long-term care insurance could play a broader role in the long-term care financing mix. However, given the substantial role already played by Medicaid, and the limited applicability of long-term care insurance for the non-elderly disability population, the potential for private long-term care

insurance, even reformed, to finance our future long-term care needs should not be overstated.

Thank you very much for your time and your consideration.
[The prepared statement of Dr. Rowland follows:]



**THE KAISER COMMISSION ON
Medicaid and the Uninsured**

FILLING IN THE LONG-TERM CARE GAPS

Testimony of Diane Rowland, Sc.D.

Executive Vice President, Henry J. Kaiser Family Foundation

Executive Director, Kaiser Commission on Medicaid and the Uninsured

Before the U.S. Senate

Special Committee on Aging

Hearing on

"Role of Private Insurance in Long-Term Care"

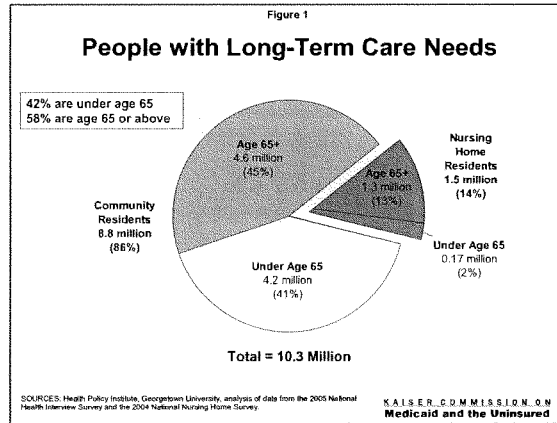
June 3, 2009

Mr. Chairman and members of the Committee on Aging, thank you for the opportunity to participate in this hearing on long-term care. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. I am also an Adjunct Professor of Health Policy and Management in the Bloomberg School of Public Health at The Johns Hopkins University. My testimony today will focus on how our nation's long-term care system is financed and the key challenges to providing a larger role for private long-term care insurance in financing long-term care for the elderly and people with disabilities.

Who Needs Long-Term Care?

Over 10 million Americans, or almost 5 percent of the total adult population, need long-term services and supports to assist them in life's daily activities (Figure 1). Although the majority of individuals who receive long-term care services are age 65 and above, 42 percent are people with disabilities and chronic illness under age 65. The majority of those with long-term care needs live in the community. Today's nursing home population consists of 1.5 million individuals, most are over age 85, female and widowed. Disease prevalence is higher, and multiple conditions are more common, among nursing home residents today, indicating an increasingly sicker population.

Long-term care includes a range of services and supports that assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLS). These range from providing assistance with eating, dressing, and toileting, to assisting with managing a home, preparing food, and medication management. The need for long-term care arises from various causes, including disease, disabling chronic conditions, injury, developmental disabilities, and severe mental illness.



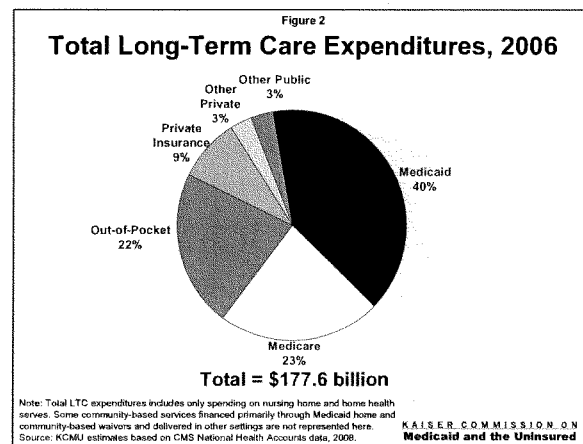
People with long-term care needs span all ages and have diverse needs for services. Some people require care over a lifetime while others may need relatively brief periods, weeks or months, of assistance. Long-term services and supports are especially vital for individuals with disabilities under the age of 65. These include children with intellectual disabilities such as mental retardation and developmental disabilities such as autism, young adults with spinal cord and traumatic brain injuries and those with serious mental illness. Older people with Alzheimer's disease often need some long-term services due to decreasing mobility and cognitive functioning that comes with aging, and those with severely disabling chronic diseases such as diabetes and pulmonary disease need more extensive acute and long-term services as they age.

Individuals receive long-term services in a variety of settings including their own homes, adult day centers, assisted living facilities, and nursing homes. The majority (86 percent) of people with long-term services needs live in the community and about 14 percent live in nursing facilities. Most people rely on unpaid help to meet their long-term services needs. Nearly 80 percent of all people with long-term care needs who live in the community have care that is provided by their friends and family. Only a small fraction (8 percent) relies exclusively on paid assistance.

How is Long-Term Care Financed?

Many people who need long-term care rely primarily on unpaid help from family and friends. Paying for long-term services is expensive and can quickly exhaust lifetime savings. Nursing home care averages \$70,000 per year, assisted living facilities average \$36,000 per year, and home health services average \$29 per hour. The cost of these services often exceeds individuals' ability to pay for their care. Most long-term services and supports (including extended stays in nursing homes) are not covered by Medicare, and few people have private long-term care insurance to help pay for nursing home stays.

In 2006, nearly \$178 billion was spent on long-term services (Figure 2). Medicaid accounts for 40 percent of total long-term care spending. Medicare accounts for slightly less than one-quarter of spending, direct out-of-pocket care spending by individuals and families accounts for 22 percent, and private insurance accounts for about 9 percent of spending.



Medicare primarily covers physician and hospital-based acute care services and does not play a large role in financing long-term services. However, because it is difficult to draw a bright line between acute care and long-term care services, Medicare does cover some services that could be considered long-term care. For example, Medicare covers up to 100 days of nursing home care for patients needing skilled nursing or rehabilitation services following a hospital stay.

Medicare also covers home health services, without limit, but only while patients require skilled nursing care. These services are primarily intended as short-term transitional care as part of rehabilitation from an acute care episode and do not meet the needs of those with chronic illness or ongoing need for assistance.

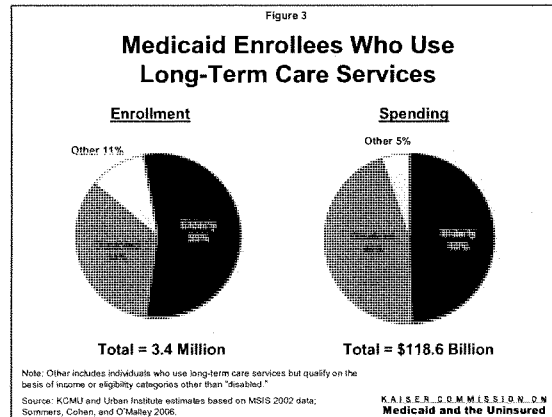
Medicare was enacted because the private health insurance market did not work for the elderly. Medicaid was designed as a companion program that provided wrap around services, including nursing home care that Medicare did not provide. Over time, Medicaid has evolved to become the primary payer for long-term services and supports to low-income individuals and a safety net for those who become impoverished as a result of long-term care needs.¹ Because Medicaid is often the only source of coverage for these services, it plays a unique role in our health care system, helping to fill in the gaps in private coverage and Medicare. Medicaid is intended to assist low-income individuals and is not available to everyone who needs long-term services. To qualify for Medicaid individuals must meet stringent income and asset criteria and apply most of their monthly income, including social security payments, toward the cost of care.

Most individuals self-finance their long-term care needs because, unlike insurance for health care services, relatively few people have private insurance for long-term care. Individuals often express reluctance to purchase private long-term care coverage because it is expensive and they are uncertain about their risk of disability and service needs 20 or 30 years in the future. People with chronic conditions and disabilities are excluded from coverage by pre-existing conditions, regardless of its affordability. Also, private long-term care insurance is primarily offered through the individual market which has limitations – even for health insurance, only 6 percent of individuals obtain coverage through the individual market where potential immediacy of needing coverage is more apparent. Private long-term care insurance has rarely been offered as part of employer sponsored insurance and when it has been offered, take-up rate has been low.

Public Funding of Long-Term Care through Medicaid

Medicaid plays a critical role for low-income people of all ages with long-term care needs. Persons 65 and older constitute over half (55%) of those who use Medicaid long-term care services, but roughly one-third (34%) are individuals under age 65 with a disability (Figure 3).

Another 11 percent are adults and children who rely on Medicaid's long-term services and supports, but became eligible for Medicaid through pathways other than disability.

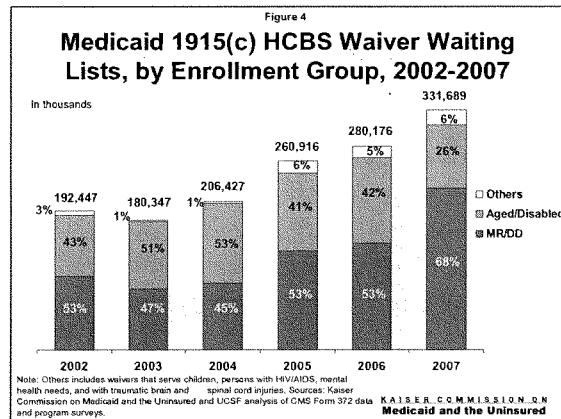


Medicaid's strict eligibility rules require people who need long-term care to spend-down all of their assets and contribute nearly all of their income to the cost of care. Many elderly people in the community have already spent their retirement savings supporting themselves in retirement and paying for care in the community – and thus qualify for Medicaid at admission to the nursing home. They must, however, contribute their entire income, including pension and social security payments (except for a small personal needs allowance) to the cost of care. Others with modest savings above Medicaid's resource thresholds must spend down their available assets before they can qualify for assistance.

Medicaid partnership programs were designed to help bridge the gap between private long-term care insurance and Medicaid. Currently at least 30 states have partnership programs in place. Partnership programs are insurance policies in which Medicaid disregards an amount of assets or resources when determining eligibility for Medicaid equal to the insurance benefit payable under the insurance policy. This disregard allows policyholders to retain a certain portion of their assets and qualify for Medicaid coverage.

There is considerable diversity in the services used and the settings where these services are provided among those who rely on Medicaid to meet long-term care needs. Nursing home

services are used predominantly by older people, while home and community-based services serve a broad age spectrum but are especially important for younger disabled people. Medicaid covers services needed by people to live independently in the community such as home health care and personal care, as well as services provided in institutions such as nursing homes. While many people prefer to remain in their homes, some individuals with extensive needs require nursing home care. States are required by the federal government to pay for institutional care because it is a mandatory benefit, but long-term care services in the community, such as personal care and waiver services, are provided at state option. Over the last two decades, states have been shifting more of their resources towards home and community-based services and away from institutional settings, as a result of the Olmstead decision and consumer preferences. Demand for services in the community is growing and currently 2.8 million individuals are being served through Medicaid home and community-based services. The number of individuals who can participate in these programs is limited; however, as evidenced by the 331,000 individuals on waiting lists for services in 2007 (Figure 4).²



Private Funding of Long-Term Care

American families today are struggling to pay for long-term care, particularly in the current environment. Individuals and families are caught in the crosshairs of an economic meltdown dramatically reducing the personal resources that have fueled over 25 percent of the nation's

long-term care spending until now. These sources of out-of-pocket financing, which include home equity, personal savings, and income from adult children, have provided critical private funding for a long-term care system in which insurance has played a very small role, covering only about 10 percent of all seniors.

The decline in personal financial resources comes at a time when states are facing negative growth in revenue collections and unprecedented budgetary shortfalls, pressuring them to find ways to trim their budgets for state programs such as Medicaid, the nation's long-term care safety net and major financing source for long-term care. Medicaid pays for approximately 70 percent of nursing home patients, 12 percent of assisted living residents, and nearly all people with developmental disabilities. Reductions to Medicaid combined with a diminishing pool of private resources could worsen the long-standing funding gap between long-term care need and available financing.

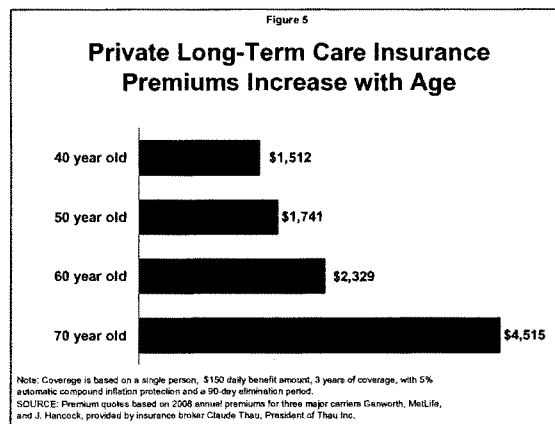
Private insurance for long-term care is still a limited option for financing care. Insurance carriers have sold about 10 million long-term care insurance policies since 1987. Of the 6 to 7 million of these that remain current, the industry sold about 4 million through individual agents and slightly more than 2 million through employers or groups. These policies specifically cover the costs of long-term care services that can include nursing home care (average cost of \$70,000 per year), assisted living facilities (\$35,000 per year), and home healthcare (\$35 per hour for a certified aide). In 2007, long-term care insurance policies paid \$4 billion in claims on behalf of disabled policyholders, a small fraction of the over \$200 billion in national long-term care spending.

Addressing the Long-Term Care Funding Gap

At the same time, federal policymakers are grappling with a contentious policy environment that could diminish their ability to use publicly funded solutions to the growing financing gap for long-term care. Priorities include addressing the federal deficit and the concern over the impact of rising health costs on entitlement programs like Medicare and Medicaid. Some policymakers may consider these policy goals to conflict with adding federal funds to the long-term care system through new programs or other public solutions. Facing multiple priorities and scarce public dollars, policymakers may be interested in exploring whether private long-term care insurance could play a larger role in financing America's long-term care needs.

In assessing the potential for broader application of long-term care insurance in the financing mix for long-term care, it is important to highlight questions such as: how adequate is the coverage from these policies, how well does the market work, what protections are in place for consumers, and what transparency is offered? We have reviewed many of these questions and challenges around coverage and financing of long-term care in a report by the Kaiser Commission on Medicaid and the Uninsured entitled, "Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance," which we have submitted for the record.³ Key findings from the report include:

Cost is a key barrier to expanding the role of private insurance. People who shop for, but do not buy, long-term care insurance cite cost as the most important reason for their decision. Premium amounts vary by age at purchase. For individuals age 60 with no partner, the annual premiums for a typical policy averaged \$2,329 across three products offered by three major carriers (Figure 5). For a couple the same age, premiums for the same policy design averaged \$3,096 combined for the two people. If purchased at age 70, premiums would cost, on average across these products, \$4,515 per year for an individual and \$6,010 for a married couple. Policymakers seeking to increase the purchase of long-term care insurance will have to address its cost and the ability of consumers to pay premiums.



In general, the majority of long-term care insurance purchasers buy their policies directly through individual insurance sales agents. These purchasers are usually married, in their late

50s, and more financially secure than the overall population. About 50 percent of people buying long-term care insurance earn above \$75,000 annually compared to 31 percent of the general population age 50 and older. Three-quarters of purchasers have liquid assets (i.e., assets not including the home) over \$100,000 compared to 30 percent of the general population. About 16 percent of long-term care insurance buyers earn less than \$35,000 annually.

Health risk can deny consumers coverage. Before purchasing insurance, many consumers must undergo a detailed health screening and evaluation to determine their insurability and risk rating. Underwriting techniques assess the applicant's likelihood of developing a cognitive impairment or chronic degenerative condition that carries a high risk of needing long-term care. Industry experts estimate that 15 to 20 percent of those who apply do not get coverage. Once an insurer accepts an applicant, the insurer will place him or her into one of three health risk categories: preferred, standard, or substandard. A substandard rating would result in the highest premium, all other things being equal. Policymakers interested in promoting the role of private long-term care insurance will need to seek ways to reduce coverage denial rates or provide private financing alternatives for individuals denied coverage.

Buyers face complex product design issues. The complexity of today's long-term care insurance products reflects a market in which consumers traditionally have worked with individual agents to tailor products along multiple dimensions such as how much they will receive in daily benefits, how long the coverage will last, and how their benefits will be protected from inflation. Even policies with the same design elements can differ from one insurance carrier to another in even more subtle ways such as the definition of certain services. Any policy effort to expand the marketing and appeal of long-term care insurance to a broader group will require product simplification and consumer education.

Time lag between purchase and use of benefits creates problems in service use. One of the major challenges of long-term care insurance is the time lag element, since it can be 20 to 30 years before the purchased insurance is used. Before paying benefits under a long-term care insurance policy, an insurer must determine that the policyholder has a significant disability that necessitates long-term care. When Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, it specified how disabled an insured person must be and how to measure that disability in order for the policyholder to receive benefits under a tax-favored long-term care insurance policy. Nearly all policies sold today define and measure need

for long-term care according to HIPAA. These disability requirements, which are worse than health insurance, are referred to as “benefit triggers” and they can either be physical or cognitive.

Changing service definitions and the evolution of new forms of residential care as well as the advent of assistive technologies test the flexibility of long-term care insurance products. Unlike well-understood and defined services such as nursing home and home care, assisted living and other forms of residential care do not always meet the service definitions contained in long-term care insurance policies. Future users of long-term care may receive assistance at home from a range of technologies that include motion sensors and other remote monitoring devices. While the alternate plan of care feature may provide some coverage of assistive technology, today’s contracts do not explicitly cover technology nor are they designed for the type of large one-time purchases that home technology installations may require. Policymakers must consider how to ensure the product flexibility that will provide today’s purchaser with tomorrow’s services and technology.

Employer-based market offers promise but adequacy of coverage is a concern. At the same time that private long-term care insurance policies sold individually by agents have been declining, insurers have been selling a growing number of long-term care insurance policies through employers or other groups. Product options sold in this manner are often simpler than the individual market and underwriting is more limited. However, buyers in the group market tend to earn less than buyers in the individual market and therefore opt for less expensive policies in which benefits do not automatically grow with inflation. Policymakers interested in boosting the employer-based market must carefully consider how to balance growth among younger consumers with the need to ensure that inflation does not erode their coverage over time. At the same time, employer-based health coverage is being scaled back and retiree health coverage is eroding making this market’s viability uncertain.

Medicaid Partnership Program will shape products and the market. At least 30 states have approved state plan amendments to participate in a long-term care insurance partnership program with Medicaid that allows long-term care insurance policyholders to qualify for a Medicaid asset disregard. This disregard allows policyholders to retain a certain portion of their assets and qualify for Medicaid coverage. A policyholder who receives \$150,000 in benefits from his or her long-term care insurance policy, for example, and meets all other program

requirements can qualify for Medicaid using an asset test that is \$150,000 higher than the ordinary Medicaid asset test (which is typically \$2,000). One potential outcome of this program is that, going forward, nearly every policy sold in the 30 or more partnership states will likely qualify for the program and therefore include a Medicaid asset disregard. This makes Medicaid an integral component of many private long-term care insurance policies. Any policy effort to expand the role of private insurance should consider explicitly how the Medicaid partnership program can complement and work in tandem with other efforts to attract long-term care insurance purchasers.

Conclusion

As the nation faces a growing elderly population and the potential for a substantial increase of people in need of assistance with long-term care, it is important that we move now to address how to structure and pay for the long-term care services that will be required. Broadening the ability of individuals and families to pay for care when needed through their own resources should be a central component of any approach. Extending the reach of private long-term care insurance can help support the care for more families than are helped today by the limited reach of private coverage.

However, if long-term care insurance is to become more available and utilized, the limitations of the current private long-term care insurance market should be examined and addressed as part of creating a broader market. Many of the concerns that have led to the current health reform efforts focusing on regulation and changes in the individual health insurance market apply equally to the current long-term care market. Most notably, high administrative costs, unaffordable premiums, exclusion based on health status, and complexity and lack of comparability across plans would all have to be addressed as part of reforming and extending the private long-term care insurance market.

With such revisions, private long-term care insurance could play a broader role in the long-term care financing mix. However, given the substantial role already played by public coverage through Medicaid and the limited applicability of long-term care insurance for the non-elderly disability population, the potential for private long-term care insurance to finance our future long-term care needs should not be overstated.

Thank you for the opportunity to discuss these critical issues with the Committee today. We look forward to working with the Committee to identify ways to broaden and improve the availability and affordability of long-term care services for the many Americans with chronic illness and disabilities as the nation faces the challenge of an aging population.

ENDNOTES

¹ Judith Kasper, Barbara Lyons and Molly O'Malley, "Long-Term Services and Supports: The Future Role and Challenges for Medicaid," The Kaiser Commission on Medicaid and the Uninsured, September 2007, <http://www.kff.org/medicaid/7671.cfm>.

² Terence Ng, Charlene Hamington and Molly O'Malley, Medicaid Home and Community-based Service Programs: Data Update, Kaiser Commission on Medicaid and the Uninsured, December 2008. <http://www.kff.org/medicaid/7720.cfm>

³ Anne Tumlinson, Christine Aguiar, and Molly O'Malley Watts, "Closing the Long-Term Funding Gap: The Challenge of Private Long-Term Care Insurance," The Kaiser Commission on Medicaid and the Uninsured, June 2009.

The CHAIRMAN. Thank you so much.
Now, we'll hear from Sean Dilweg.

**STATEMENT OF SEAN DILWEG, INSURANCE COMMISSIONER,
WISCONSIN INSURANCE COMMISSION, MADISON, WI**

Mr. DILWEG. Thank you, Chairman Kohl and Ranking Member Martinez. Thank you for the opportunity to testify concerning the regulation of long-term care insurance. I appreciate you holding this hearing today in an effort to highlight the long-term care insurance and the complex issues related to it.

Long-term care insurance has proven to be a very challenging product to regulate. Setting this product apart from other lines of insurance is the span between the purchase of long-term care insurance and when that person actually needs coverage for the services.

Products currently for sale will provide coverage for services in most cases 10 to 15 years down the road. Regulators are in the unique position of reacting to decisions consumers and industry made 15 years ago, while also facing the challenge of ensuring policies purchased today provide meaningful coverage in the next 15 years.

State regulators have three main priorities in regulating these products. First, ensuring the solvency of the companies offering the long-term care policies so that companies can pay the claims for the policies they have sold.

Second, ensuring that sufficient consumer protections are in place so that the premiums are relatively stable over the life of the policy, and consumers receive the benefits promised to them in a timely manner.

Third, ensuring that all long-term care insurance sales are done in an appropriate and suitable manner.

The first, solvency, is one of the most important responsibilities of the State insurance regulator; it's to ensure the solvency of the company that is doing business in the market. Over many years, State insurance regulation has developed a solvency regulatory system grounded in each of the States, and coordinated through the National Association of Insurance Commissioners. This has served insurance consumers well.

It is my responsibility, as the insurance regulator of Wisconsin, to ensure insurance consumers are protected from poor business decisions made by those few companies so that obligations under their insurance contracts are fulfilled. This preventative approach to regulation—early detection of potential financial difficulty—is by far the best way to achieve this goal.

So, to that end, State insurance regulators have developed a very sophisticated financial analysis system, along with an insurance company financial database that is second to none.

Many of the problems we see today are the result of older long-term care policies sold when there were insufficient regulations in place to address these problems. Today, the regulatory structure of long-term care insurance has evolved, and the market seems to have stabilized. The newer long-term care policies are sold at a more realistic, and thereby more suitable, price.

In identifying the stabilization of premium, some insurers in the nineties priced primarily for market share, and offered the least expensive policies available. However, when claims started to come in beyond what they priced for, these insurers had to raise their prices to cover the claims.

In some instances, significant price increases were imposed. In fact, some insurers dropped out of the market entirely by selling their business to other long-term care insurers, while others simply stopped issuing new policies. Finally, a few companies became financially hazardous, and more drastic regulatory action was taken to protect the policyholders.

Recognizing the problem of underpricing early on, State insurance regulators, working through the NAIC, developed rate stability standards and protections against premium increases. Examples include requiring insurers to actuarially certify that the rates they file will not—under moderate conditions—increase over the life of an insurance policy. If premiums rise above a given level based on the age of policyholders, for a majority of policyholders, the company is required to file a plan for improving the administration and claims processing.

If an insurance commissioner believes that a rising rate spiral exists, he or she may require a company to offer policyholders affected by the premium increase the option to replace their existing policies with comparable ones being sold.

As a last resort, the Commissioner can determine that a company has persistently filed inadequate initial premium rates and may ban the company from the long-term care insurance marketplace for up to five years.

The question of suitability has always been an issue with these products. In response to suitability concerns, many States in the NAIC developed suitability standards, and processes, to minimize unsuitable sales of long-term care insurance policies. In the State of Wisconsin and with many other States, we always emphasize never to buy long-term care insurance in a vacuum. It should be part of a much larger look at your retirement needs.

As we move forward, State regulators will continue to carefully monitor the market. Just last year, the Senior Issues Task Force at NAIC did a data call of 83 percent of the market, which included 23 of the largest individual long-term care insurers. This survey indicated that the long-term care insurance market has shown some growth, especially with regard to comprehensive coverage products that provide insurance for both institutional and non-institutionally based care.

The data also showed that claims handling problems—although increasing in absolute numbers—currently do not appear to be statistically significant. We did convene a subgroup that is working on an independent review model that would provide the consumer with a very good tool—when they face claim problems—that triggers an independent review of the claim before them.

As we look at the other issues surrounding long-term care insurance, we feel—I feel—that the Federal Government can play a role. You have control over the tax-qualified long-term care insurance policies, and there is also the Long-Term Care Insurance Partnership Program.

As I look at the bill that you've introduced today, I think it's appropriate that the Secretary of Treasury, and the Secretary of the Department of Health and Human Services review all subsequent amendments to the NAIC long-term care insurance models to determine whether they should be required for tax-qualified and partnership policies. I appreciate that your bill sets forth a process for accomplishing a number of these goals.

You also recognize the value of State regulatory authority over long-term care insurance as well as the significant impact of NAIC models developed in collaboration with all of the interested parties.

I know the NAIC will look forward to reviewing your proposal much more closely as it moves forward. Thank you for the time.

[The prepared statement of Mr. Dilweg follows:]

Testimony of

**Sean Dilweg
Wisconsin Commissioner of Insurance**

**Before the
Senate Special Committee on Aging**

“Boon or Bane: Examining the Value of Long Term Care Insurance”

**June 3, 2009
2:00 P.M.**

Good afternoon Chairman Kohl, Ranking Member Martinez, and members of the Committee. Thank you for the opportunity to testify concerning the regulation of long-term care insurance. My name is Sean Dilweg, and I am the Insurance Commissioner for the State of Wisconsin. The primary objective of insurance regulators is to protect consumers of all lines of insurance, including long-term care insurance, and to ensure that insurance markets function appropriately and efficiently.

I would like to begin by thanking you for holding this hearing on a very important topic. As our population ages, more and more Americans will be confronted by the need for long-term care services and the financial burden of paying for that care. Already, long-term care services account for over half of all Medicaid spending in the United States, adding to the strain of health care costs on state budgets. Long-term care insurance is one way to finance these costs, providing individuals with protection against the financial burdens associated with the need for long-term care services.

Long Term Care Insurance has proven to be a very challenging product to regulate. In this testimony, I will briefly discuss the long-term care marketplace, the types of policies available, as well as the difficulties that regulators have encountered and the steps that have been taken to overcome them. Finally, I will discuss current and future National Association of Insurance Commissioners (NAIC) activities dealing with long-term care insurance, as well as federal involvement in the marketplace.

For those who have accumulated savings over their lifetime, long-term care insurance can be a way to protect some of their assets in the event they enter a nursing home or assisted living facility, or receive long-term care services in another setting. Whether to purchase a long-term care insurance policy is an individual decision and should take into account the potential purchaser's age, health status, overall retirement goals, income, and assets. For instance, if an individual relies solely upon Social Security as an income source, their income is not likely sufficient for them to afford long-term care insurance. Individuals should not purchase long-term care insurance if paying premiums will prevent them from paying other important bills, such as shelter, food and clothing expenses, or if they are already enrolled in Medicaid.

For consumers with significant assets, a long-term care insurance policy may be a good way to protect their assets against large long-term care expenditures. For these people, long-term care insurance may be a viable option.

Last year, the average annual cost of nursing home care was nearly \$76,500, while assisted living facilities cost, on average, about \$36,100 per year¹, amounts that could quickly deplete even a sizeable retirement nest-egg. People pay for this care in a variety of ways. Some choose to set aside a portion of their savings to finance long-term care, while others, who have fewer assets, will rely upon the Medicaid program to fund their long-term care needs. For some, long-term care insurance may be the best way to finance this care.

Those who elect to purchase long-term care insurance pay a premium to mitigate the risk of incurring long-term care expenses, which may not occur until well into the future. Long-term care insurance policies provide protection, up to the limits of the policies, against the financial burdens of long-term care, thus protecting some of the assets that have been accumulated over the years. With long-term care insurance, policyholders usually have greater flexibility in choosing the source of their care than they would if they were relying upon the Medicaid program.

In the future, long-term care insurance could also be an important product from the perspective of state and federal Medicaid budgets. Approximately 40 percent of all long-term care and 50 percent of all nursing home care is financed by state and federal governments through Medicaid.² Additionally, demographic trends are likely to increase the expenditures of long-term care services to governments, at the same time that the percentage of Americans who are of working age and paying taxes to support Medicare and Medicaid decreases. To the extent that long-term care insurance is able to help people avoid spending down their assets in order to receive care through Medicaid, long-term care insurance may be helpful to state and federal Medicaid budgets.

The Long-Term Care Insurance Market

Though long-term care insurance, in its current form, has been available since the 1980s, it is still a relatively new product. The first long-term care policies, issued in 1965, were designed to supplement the limited benefits provided by the new Medicare program for skilled nursing facility care. These early long-term care policies functioned much like Medicare supplement policies, covering deductibles and coinsurance associated with care in a skilled nursing facility that was covered by Medicare. For this reason, they, like Medicare, required that the policyholder spend at least three days in the hospital prior to their admission to the skilled nursing facility and required that care in the facility be “medically necessary.”

By the 1980s, long-term care insurance had evolved into a product that stood on its own. It still generally covered only nursing home care, but it no longer was designed to wrap around Medicare’s skilled nursing facility coverage. It covered nursing home admissions even if they were not immediately preceded by a hospital stay, as required under Medicare. The benefit triggers were redefined from a medical necessity trigger to the policyholder’s inability to perform defined activities of daily living (ADLs) and cognitive impairment.

Since that time, the product has further evolved by adding more comprehensive coverage for additional types of long-term care services, such as home health

care, respite care, hospice care, personal care in the home, and services provided in assisted living facilities, adult day care centers and other community facilities. Furthermore, in addition to individually purchased policies, group long-term care insurance policies began to make up a significant and growing portion of the market.

As the long-term care insurance product has developed, so have the states' long-term care insurance regulatory programs. States enacted additional consumer protections designed to keep up with changes in policy design and pricing and address the problems encountered in the market place by consumers.

Though long-term care insurance has not been a major player in funding today's long-term care expenditures, financing less than 10 percent of long-term care services in the United States, it has been growing steadily in recent years. In the past ten years, the market has grown from one that covered less than 3 million lives to one that now covers more than 7 million. In terms of premium volume, the market has grown from a \$16 billion marketplace to one in which consumers paid over \$110 billion in premiums in 2007.³

One factor in the growth of long-term care insurance has been the growth in sales of group long-term care policies offered as employment benefits. Group policies have grown from a small portion of the market to approximately 20 percent in 2006 and continue to grow faster than individual plans. One advantage of group coverage is that enrollees may not be required to meet medical underwriting requirements in order to purchase coverage, or the medical screening criteria may be more relaxed than for an individual long-term care insurance policy. Generally, group coverage may either be continued after an individual's employment ends, or the policy may be converted into an individual long-term care policy, though benefits and premiums may change.

In 2002, the federal government began offering long-term care insurance to its employees and their family members through the Federal Long-Term Care Insurance Program. As of September 2006, approximately 214,000 federal

employees and their families had enrolled in the program, making the federal government the largest group sponsor of long-term care insurance in the country.

Another factor in the growth of long-term care insurance has been the deductibility of all or part of the premiums of tax-qualified long-term care policies. The Health Insurance Portability and Accountability Act (HIPAA) includes standards for qualified long-term care insurance policies, which must meet a number of consumer protection standards drawn from the NAIC's Long-Term Care Insurance Model Act and Regulation. The tax treatment that accompanies tax qualified long-term care insurance policies is that premiums are considered a Schedule B itemized deduction, the same as medical expenses, after meeting the 7.5% of adjusted gross income limit. In addition, the law clarified that benefits received from tax qualified long-term care insurance policies are not considered taxable income. In 2002, 90 percent of individual long-term care insurance policies were tax-qualified.⁴

Finally, the product itself has evolved significantly in recent years by providing more comprehensive coverage, more stable premiums and consumer protections that make it more attractive in the market. These improvements to the product were, in part, the result of a collaborative effort between the long-term care insurance industry, state insurance regulators (NAIC) and consumer advocacy groups to improve the coverage and the market for long-term care insurance.

More recently, the Deficit Reduction Act of 2005 (DRA) included a provision authorizing long-term care (LTC) partnerships. A LTC Partnership program allows an individual with a qualified long-term care insurance policy to retain a portion of the policyholder's assets for the purposes of Medicaid eligibility determination and protect those assets from estate recovery. The level of asset protection provided is equal to the amount of benefits paid by the policy. Partnership policies must be tax-qualified and contain all consumer protections required of a tax qualified plan and must provide inflation protection for all policies issued to those under 76 years of age.

The Regulation of Long-Term Care Insurance

Long-term care insurance has, for several reasons, been a particularly challenging product to regulate. Besides being a relatively new product with claims experience just beginning to accumulate, the product combines both life and health insurance features in a single product. The product is sold as a means to mitigate future long-term care expenses where those expenses may not occur until fifteen to thirty years into the future, depending upon the age at which the policy was purchased, much like a life insurance policy. Once the policyholder develops a condition that makes them eligible to collect benefits, however, the policy acts more like a health insurance product. As in the health care industry, long-term care services are evolving and are subject to high levels of inflation in the cost of services and growing utilization of the services. Long-term care policies need to be able to provide meaningful coverage at the time they are needed in this evolving environment. Long-term care insurance is also subject to the same rapid changes in delivery of care that affect health insurance. The combination of these factors results in a situation where insurers must price their insurance policies so that they will pay for services fifteen or thirty years from the date of purchase of the coverage, when the cost, utilization and nature of those services may have radically changed.

Coping with these and other regulatory challenges in this market requires a determined effort and constant attention from state regulators. Our three main priorities in regulating these products are (1) ensuring the solvency of companies offering long-term care policies so that the companies can pay claims for the policies they have sold; (2) ensuring that sufficient consumer protections are in place so that premiums are relatively stable over the life of the policy and that consumers receive the benefits promised them in a timely and accurate manner; and (3) ensuring that all long-term care insurance sales are done in an appropriate manner and are suitable for those purchasing the policy.

Solvency

One of the most important responsibilities of state insurance regulators is to ensure the solvency of the companies doing business in the market. This applies to all lines of insurance, including long-term care insurance. State insurance laws and state insurance regulators take this consumer protection very seriously. Over many years, state insurance regulation has developed a solvency regulatory system, grounded in each of the states and coordinated through the National Association of Insurance Commissioners (NAIC), that has served insurance consumers well. Today, this is evidenced by the relative financial stability in the insurance market place during these extraordinarily difficult economic times.

The state-based insurance solvency regulatory system reflects conservative solvency standards developed by the states and, in some cases, the NAIC, and shared amongst the states through various means, including minimum reserving standards, minimum capital and surplus requirements, statutory accounting principles, and NAIC state insurance department accreditation. In addition, states have developed, internally and through the NAIC, a financial analysis and monitoring system that targets potentially troubled, nationally significant insurers for regulatory action and monitors domiciliary state activity on these companies. While the primary solvency regulatory authority lies with the domiciliary state, the insurer's home state, the NAIC offers assistance to the domiciliary state through its Financial Condition Committee structure, if requested. Those non-domiciliary states in which a potentially financially troubled insurer does business also have the ability to take regulatory action they deem necessary to protect their consumers.

The above standards and processes apply to the regulation of long-term care insurers as well. In virtually all states, long-term care insurers are required to maintain a minimum amount of claim reserves based upon the amount of business they write. Additionally, long-term care insurers are subject to the same conservative statutory accounting principles as other insurers and are subject to the same rigorous financial analysis by their domiciliary states, non-

domiciliary states and the NAIC. Conservative asset valuation standards and conservative standards for the amounts and types of assets in which an insurance company can invest to meet its statutory financial obligations apply to long-term care insurers.

Even with these conservative solvency standards and rigorous oversight, a few insurance companies will get into financial difficulty. So long as we have a competitive marketplace in a capitalistic economic system, there will be companies who are successful and there will be a few who are not. It is my responsibility, as an insurance regulator, to ensure insurance consumers are protected from poor business decisions made by those few companies so that the obligations under their insurance contracts are fulfilled. Early detection of potential financial difficulty is, by far, the best way to achieve this goal. To that end, state insurance regulators have developed a sophisticated financial analysis system along with an insurance company financial data base that is second to none.

Early detection gives the company and the regulator an opportunity to address financial problems before they result in potential consumer harm and more formal regulatory action. Corrective business plans can be developed, implemented and carefully monitored to determine whether they can bring the company out of its financial difficulty.

If the situation is such that a rehabilitation or receivership is required, early detection and action on a financially troubled insurer minimizes the amount by which a financial hole needs to be filled. It also allows the rehabilitator or liquidator to develop a strategy to sell or transfer the troubled company's insurance business to another, financially healthy insurer thus minimizing any disruption to the policyholders. As a last resort, if no other insurer can be found for the business, the insurance guaranty funds are activated to provide protection for the troubled company's policyholders and claimants.

These consumer protections have been developed and refined over many years. They continue to serve the insurance market place well. Of course there are

instances where state insurance solvency regulation could have performed better. However, the important thing to realize is that insurance regulators have learned from these situations and have adjusted their solvency regulatory processes accordingly. My colleagues and I are very confident that state insurance solvency regulation is one of the best financial services regulatory processes in the world. Additionally, insurance regulators are committed to continuously improving an already successful system.

The NAIC is continually monitoring these standards to determine if they are achieving their intended goal, and, if not, works to improve them. Many of the problems we see today in the long-term care insurance market are the result of long-term care policies sold when there were insufficient regulations in place. Today, the market seems to have stabilized and the newer long-term care insurance policies are sold at a more realistic and thereby more suitable price.

Stabilizing Premium

Long-term care insurance is a very difficult product to price for two reasons. First, claims for long-term care insurance are likely not to occur until fifteen to thirty years after a policy has been sold. Second, the long term care services delivery system is an ever-changing system.

For example, when long-term care insurance first came onto the market, it was primarily nursing home care coverage. That has now evolved into not only nursing home coverage, but adult day care coverage and home care coverage, to name a few. To price for this type of coverage, so that the prices are stable, competitive and profitable, is very difficult, especially with the uncertainty in the market place.

Some insurers in the 90's priced primarily for market share and offered the least expensive policies available. However, when claims started to come in beyond what they priced for, these insurers had to raise their prices to cover claims. In some instances, significant price increases were imposed in an effort to meet claim obligations and remain in business. In fact, some long-term care

insurers dropped out of the market entirely by selling their business to another long-term care insurer while others just stopped issuing new policies.

Recognizing the problem of under pricing early on, state insurance regulators through the NAIC developed rate stability standards to basically force long-term care insurers to reasonably price their products up front. These rate stability standards evolved over the years from rate increase restrictions to requiring insurers to actuarially certify that the rates they file will not increase over the life of an insurance policy under moderately adverse conditions.

The original NAIC model regulation, adopted in 1988, contained a provision that required all individual long-term care insurance policies to meet a minimum 60 percent loss ratio. This meant that over the life of the policy, a minimum of 60 percent of the premium had to go towards the payment of claims. A maximum of 40 percent of the premium could be allocated to administrative costs and profit. This requirement, though an important consumer protection to ensure that a majority of the premium was being used for paying claims, did not address the potential under pricing of policies and the resultant premium increases. In response to this problem, the NAIC adopted amendments to the model regulation in 2000 designed to ensure greater premium stability. These amendments eliminated the 60 percent minimum initial loss ratio requirement, and substituted an actuarial certification that must be filed with the initial premium rate filings, attesting that premiums will not increase over the life of the policy under moderately adverse conditions. However, in the event that future premium increases became necessary and were filed with the insurance department, the original premiums filed now needed to meet a 58 percent loss ratio, and the premium increases needed to meet an 85 percent loss ratio. Furthermore, following each rate increase, the insurer must file its subsequent experience with the Commissioner for three years. If the increase appears excessive, the Commissioner may require the company to reduce premiums or take other measures, such as reducing its administrative costs, to ensure that premium increases that turn out to be unnecessary are returned to policyholders.

The 2000 amendments to the model regulation also put in place two additional levels of protection against premium increases. If premiums rise above a given level, based upon the age of the policyholder, for a majority of policyholders, the company is required to file a plan for improved administration and claims processing or to demonstrate that appropriate claims processing is in effect. Furthermore, if the Commissioner believes that a rising rate spiral exists, he or she may require the company to offer policyholders affected by the premium increase the option to replace their existing policies with comparable ones currently being sold, without underwriting. This allows policyholders trapped in a rising rate spiral to switch to a more stable policy. Finally, as a last resort, if the Commissioner determines that a company has persistently filed inadequate initial premium rates, the Commissioner may ban the company from the long-term care insurance marketplace for up to five years, essentially putting the company out of business in the state.

These changes created a strong incentive for companies to price policies accurately up-front, in an effort to avoid future increases and to encourage suitable sales of the products. To assist consumers in selecting a policy with premiums that do not drastically increase over time, insurers are required to disclose to prospective policyholders all prior rate increases for the past ten years. I believe these provisions, plus the additional experience that companies have gained in pricing long-term care policies, will be effective in promoting long-term care insurance premium stability. Nevertheless, state regulators, on their own, and through the NAIC, will continue to watch the situation closely to see how these standards affect future premium increases.

Marketing and Suitable Sales

The long-term care insurance market has also experienced some marketing and sales challenges. In the 1980s and 1990s, the product was primarily sold to seniors. Some companies and their agents used deceptive and high-pressure sales tactics. Many sales were considered unsuitable because policies were sold to individuals who did not have the financial wherewithal to afford the premium for the long-term care insurance protection and were already close to qualifying

for Medicaid. There were also instances of improper long-term care insurance policy replacements, where one long-term care policy was replaced by another, to the benefit of the replacing insurance agent and company, but to the detriment of the consumer.

The question of suitability has always been an issue with these products. In the past, these products were sold on a standalone basis, outside of a consumer's financial plan. Now, because of all the options that consumers have to pay for long-term care services, buying a long-term care insurance policy without a financial plan would be unwise. In addition, these types of standalone sales often result in unsuitable purchases for the consumer. Consumers who have few assets to protect and are relatively close to qualifying for Medicaid should think carefully about whether they will benefit from the purchase of a long-term care insurance policy. In response to the suitability concerns, many states and the NAIC developed suitability standards and processes to minimize unsuitable sales of long-term care insurance policies.

Older long-term care insurance policies do not have some of the consumer protections that are available in the current regulatory environment especially in the area of rate stability, benefit adjustments, unintentional lapse protection, and inflation protection. Many of the problems we are seeing in today's market can be, in my opinion, attributed to policies that were issued prior to the implementation of many of the consumer protections we have today.

The NAIC's Long-Term Care Insurance Model Regulation requires all long-term care insurers to develop suitability standards, based upon general categories contained in the regulation outlined below, to determine whether the purchase of a long-term care insurance policy is appropriate for the applicant. These standards must take into account (1) the ability of the applicant to pay the premiums and other pertinent financial information related to the purchase; (2) the applicants' goals with respect to long-term care; and (3) the advantages and disadvantages of insurance to meet those goals and any insurance that the applicant may already have. The NAIC model also contains a worksheet for insurance agents to use to determine suitability prior to selling a policy. This

worksheet collects relevant information about the prospective policyholder and helps to ensure that the applicant is aware of the various options available under the policy, and the consequences of decisions regarding those options with respect to both premiums and future benefits under the policy.

The insurer must review the worksheet prior to issuing the policy. If the insurer finds that the policy would not be suitable for the applicant, based upon its suitability standards, it must either reject the application or inform the applicant that the policy may not be suitable. Written confirmation must be obtained from an applicant who wishes to purchase the policy anyway.

The NAIC Model Regulation also requires agents to provide purchasers with copies of the NAIC's "Shopper's Guide to Long-Term Care Insurance" and a fact sheet entitled "Things You Should Know Before You Buy Long-Term Care Insurance." These publications outline some of the considerations that consumers should take into account when purchasing a policy so that all consumers have the opportunity to be informed prior to committing to a purchase. All states have this requirement in their long-term care insurance regulations.

Finally, the Long-Term Care Insurance Model Act and all states' long-term care regulations provide consumers the right to return the policy within 30 days of receipt of the policy for a full refund if they are not satisfied for any reason. Notice of this right must be prominently included on the first page of the policy. This provides an opportunity for the applicant to reconsider the decision to purchase coverage and acts as a defense against high-pressure sales tactics and unsuitable sales.

State regulators work to ensure that consumers are treated fairly and receive the benefits they are entitled to under their long term care policies. Due to the fact that most policyholders are elderly and living on fixed incomes when collecting benefits under a long-term care policy, and are likely suffering from a physical incapacity, cognitive impairment or both, consumer protections for access to benefits are of the utmost importance with long-term care insurance.

States already have prompt claim payment laws that apply to long-term care insurance. The long-term care insurance market needs consumer protections for claim denials based upon the insurer's assessment of whether the policyholder has met the benefit trigger requirements under the policy. I led the work of the NAIC Long Term Care External Review Subgroup which is poised to approve model language for the implementation of an independent external review process for these types of situations. I anticipate full NAIC action on this proposal before the end of the year.

Prior to being revised in 2000 and 2006, the NAIC Long-Term Care Model Act and Long-Term Care Insurance Model Regulations already contained many important consumer protections. These protections were designed to help ensure that consumers understand what they are purchasing and that the purchase is suitable and affordable over the life of the policy. These protections include:

- **Guaranteed renewability:** All policies must either be guaranteed renewable or noncancellable. Guaranteed renewable policies may not be altered by the insurer, nor may they be cancelled except for the policyholder's failure to pay premium, but premiums may be increased. Noncancellable policies are similar to guaranteed renewable policies, except premiums may not be increased.
- **Mandatory offer of nonforfeiture benefits:** All applicants must be offered the opportunity to purchase nonforfeiture benefits, whereby if the policy were to lapse, the policyholder would be issued a paid-up policy with reduced benefits based upon the length of time the policy was held. Applicants who decline to purchase nonforfeiture benefits are still entitled to receive contingent nonforfeiture benefits, which are provided if premiums rise above a percentage of the initial premium. That percentage varies depending upon the policyholder's age at the time of purchase of the policy and ranges from 200 percent, for those purchasing prior to age 30, to 10 percent, for those purchasing after age 90.

- **Limitation on benefit triggers:** The conditions that must be satisfied before the policyholder becomes eligible to collect benefits are known as “benefit triggers.” Benefits must be triggered when no more than three activities of daily living (bathing, dressing, eating, continence, toileting, and transfer) are impaired or the policyholder suffers from cognitive impairment. Additional benefit triggers may be added, but the policy may be no more restrictive than the model’s requirements.
- **Limitations on rescissions:** Policies may only be rescinded for fraud or misrepresentation during the first six months of the policy. After that time, and for the first two years of the policy, policies may be rescinded for material misrepresentations that pertain to the condition for which benefits are being sought. After two years, policies are incontestable, except for intentional and knowing misrepresentation of relevant facts about the insured’s health. Once a policy is rescinded, previously paid benefits may not be recovered by the company.
- **Limitations on post-claims underwriting:** Health questions on an application must be clear and unambiguous. For applicants over the age of eighty, insurers must receive health information through a physical examination, an assessment of functional capacity, an attending physician’s statement, or medical records.
- **Mandatory offer of inflation protection:** Applicants must be offered the opportunity to purchase inflation protection in the form of compound annual inflation protection of at least 5 percent or the opportunity to increase benefits by at least 5 percent every year without additional underwriting, as long as previous offers to increase benefits have not been declined. An applicant’s rejection of inflation protection must be explicit and in writing.
- **Protection against unintentional policy lapse:** Each policyholder must be allowed to designate an individual who will be notified at least 30 days before the policy is cancelled for nonpayment of premium. If the policyholder suffers from a cognitive impairment, the insurer must reinstate a lapsed policy if back premiums are paid within five months.

- **Prohibition on waiting periods on replacement policies:** If a policyholder who has begun collecting benefits replaces one contract with another, or the policyholder converts a group policy to an individual policy, the insurer may not require a new waiting period to be fulfilled. To qualify for this protection, the new policy must be from the same company, and the policyholder may not increase the benefits of the policy.
- **Standardized outline of coverage:** The insurer must provide a standardized outline of coverage to the applicant at the time of initial solicitation. The outline must describe the principal benefits and exclusions and limitations of the policy and must state the terms under which it may be continued or discontinued, as well as any right the company has to raise the premium. It must also inform the policyholder whether the policy is intended to be tax qualified.

More recently, regulators determined that additional changes to the models were necessary, and in December, 2006, adopted revisions to the model act and regulation. These revisions added several important new consumer protections, including a requirement that insurers offering new policies that cover new long-term care services or providers must make the new coverage available to existing policyholders. The intent of this change was to ensure that long-term care insurance coverage keeps pace with the changing nature of long-term care services.

Additionally, the model regulation was amended to require long-term care insurance policies to include a provision allowing policyholders to reduce their coverage and lower their premiums in order to avoid lapse due the policyholders' inability to pay the current premium. This provision will help ensure that if a policyholder's financial situation changes and they cannot afford their coverage at the current premium level, they can reduce their coverage to lower the premium.

Finally, new producer training requirements were put into place to ensure that agents selling long-term care insurance products, particularly Long-Term Care

Insurance Partnership policies, are properly equipped to accurately explain coverage options to consumers. Long-term care insurance is a complex product to pay for care in a constantly changing long-term care service system. As a result, it is imperative that agents and brokers selling these products are adequately trained. Under the new producer training section of the model, agents and brokers must complete eight hours of initial training before they can sell long-term care insurance and then four hours of continuing education on long-term care every two years. The training must cover state and federal requirements pertaining to long-term care services, the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services.

These changes have been in effect for two years. However, more and more states have decided to implement the Long-Term Care Partnership and, as part of that process, have revised their laws to incorporate the most recent versions of the NAIC model act and regulations. We believe that these changes will prove to be valuable consumer protections.

Moving forward, state regulators continue to carefully monitor the market and make adjustments as necessary. Last year, the NAIC's Senior Issues Task Force and Market Analysis Working Group coordinated a data call by the domiciliary states of the 23 largest individual long-term care insurers in the United States. The call collected data from 2004 through 2006 including, premiums, claim payments, consumer complaints, and the promptness of claims payments, claims denials, and cost containment expenses.

The data showed that the individual long-term care insurance industry continues to grow, with the majority of the growth in the comprehensive policies. Complaints regarding claims have been increasing over time. In part, this is to be expected, as each year there are more policies in force with policyholders at an age where claims are likely to be filed. However, the data also showed an increase in the percentage of claims being denied, from 3.2 percent of claims submitted in 2004 to 3.9 percent in 2006. While this is not a statistically significant result, it may reveal a trend that we believe needs to be

addressed. A separate survey conducted by the insurance industry found similar results.

In response to the results of the data call, the NAIC's Senior Issues Task Force is considering further revisions to its models. As I mentioned earlier, the Task Force created a Subgroup to recommend a process for independent external review of benefit trigger determinations. This consumer protection will give a consumer an outside determination of whether a policyholder has met the conditions for benefit eligibility under the insurance policy. Currently, in most states, a policyholder's only avenue for appealing claims denials are through appeals or grievances filed with the insurance company that denied the claims, complaints to their insurance department and litigation. Independent external review will give consumers a new avenue for expeditiously resolving these disputes without resorting to litigation.

As with anything developed by a voluntary organization such as the NAIC, unless there is an outside force that requires adoption, not all member states agree with or adopt suggestions promulgated by the organization. To that end, Congress could assist in making sure that the long-term care insurance standards thoughtfully developed and promulgated by the NAIC are the standards in all states; at a minimum those states that have tax-qualified long-term care insurance policies and the Long-Term Care Insurance Partnership Program. Specifically, I would urge you to consider requiring the Secretary of the Department of Health and Human Services and the Secretary of Treasury to require the rate stability standards in the current NAIC long-term care insurance models be required in the states where tax-qualified policies are authorized to be sold and in the Partnership States. In addition, the Secretaries should also be required to review all subsequent amendments to the NAIC long-term care insurance models to determine whether they should be required for tax qualified and LTC Partnership Policies.

Chairman Kohl, I appreciate that your bill sets forth a process for accomplishing much of what I have just outlined. You recognize the value of state regulatory authority over long term care insurance, as well as the

significant impact NAI C models, developed in collaboration with interested parties, bring to consumer protection. I, and I know the NAIC, look forward to reviewing your proposed legislation more closely and continuing to work with you on this very important issue.

Again, thank you for the invitation to testify here today. I look forward to answering any questions that you might have.

¹ Genworth 2008 Cost of Care Survey

² Kaiser Commission on Medicaid and the Uninsured, Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns, November 2006, accessed July 8, 2008 at <http://www.kff.org/medicaid/upload/7576.pdf>.

³ National Association of Insurance Commissioners, Long-Term Care Insurance Experience Reports for 2007, p.9

⁴ America's Health Insurance Plans, Long-Term Care Insurance in 2002, June 2004, accessed July 15, 2008 at http://www.ahipresearch.org/pdfs/18_LTC2002.pdf, p. 25.

The CHAIRMAN. Thank you very much, Mr. Dilweg. We'd like to hear now from Ms. Cutter.

STATEMENT OF CAROL CUTTER, CHIEF DEPUTY COMMISSIONER, HEALTH AND LEGISLATIVE AFFAIRS, INDIANA DEPARTMENT OF INSURANCE, INDIANAPOLIS, IN

Ms. CUTTER. Thank you, Chairman Kohl and Ranking Member Martinez. I appreciate the opportunity to speak today about regulation of long-term care insurance in terms of what Indiana's experience has been.

As you know, Indiana was one of the original four Partnership States that were established back in the early nineties to allow folks to buy long-term care policies and protect their assets from Medicaid recovery if they did exhaust the benefits of their policies.

That was implemented under then-Governor Evan Bayh who, I understand, is a member of your committee. Obviously, there was a need for some self-responsibility for those persons who could afford to take care of their own expenses for either long-term care at home, or in an assisted living facility, or in a facility of some sort.

I believe that's why we had that program implemented, was to encourage folks to do that, knowing that those who can't afford to protect themselves against those sorts of expenses are the ones who should have access to the Medicaid funding that the Federal Government does provide.

In Indiana, our Partnership experience has been very good. During the 16 years that we've sold these policies, we've written over 45,000 of them. We've only had about 72 complaints during that 16 years, either on a rate increase, or on a claim issue of some sort.

I'm sure there's all types of anecdotal information out that you've already heard about problems that folks have had with claims with long-term care. But I want to assure you, at least in Indiana, our long-term care claims are not as serious in terms of consumer complaints, as many of the other types of insurance products that we sell in the State, like auto insurance or homeowners' insurance.

So, we believe that relative to the marketplace there, we're doing a really good job. Obviously we would like to encourage self-responsibility in Indiana. We're going to conduct a massive marketing campaign this fall for consumer awareness, because we believe that private insurance is a tremendous option to have in terms of allowing people to protect themselves from these—they can be very terrible—expenses to which you've already alluded.

In general, Indiana supports the long-term care model regulation that the NAIC has developed. There are multiple features of that model that we believe would be helpful in terms of disclosure requirements, possible standardization, standards for marketing, that sort of thing.

But there is a concern that we have about the rate stabilization piece that comes from our health actuary, who has had multiple years of experience with health insurance products of all types, actually worked here at the Federal level back in the seventies for what was then called the Health care Financing Administration, and is now at CMS. He was the director of the division for actuarial creation of Part A and Part B of Medicare.

He served in several other departments of insurance, and he's worked for private consulting firms like Deloitte, so I value his expertise and his counsel on this particular piece of the model as it concerns rate stabilization.

Currently, in Indiana—as in most States that follow any sort of standards that have been established by the NAIC—we have what is called a 60 percent loss ratio standard.

This means that before an insurer, such as Genworth, can come to us and ask for a rate increase, they have to prove to us that they have spent 60 cents, or more, out of every dollar that they've collected in premium for claims over the lifetime period of that policy, however many years that policy form itself has been sold. Until they do that, they can't even ask for a rate increase.

A lot of the actuarial information that we're getting from carriers now is what we call very highly assumptive driven. For instance, they could say, "We've had this particular policy on the marketplace for the last 12 years. We are now at a 79 percent loss ratio, which means we qualify to ask for a rate increase, because we're over the 60 percent threshold. Based upon that 79 percent loss ratio, we predict that over the next 20 years, or the next 10 years, or the next 15 years, we're going to have similar loss ratios, because of that same percentage increase in terms of claims that we're going to pay out. Therefore, we deserve to have a larger rate increase."

Our concern is, that under NAIC's rate stabilization model, Indiana's ability to control that would be taken away. There is an exceptional increase provision in here that says if I, as an insurer, can actuarially prove to you, the Department of Insurance, that we have a 70 percent loss ratio, then with those certain attestations, I'm automatically going to be allowed to have that.

We very carefully scrutinize our rates that come into our Department—for all of our products—but particularly for long-term care. We hold carriers—if they have been sitting for four or five years and have had incurred claims that put them into a deficit ratio on their dollars, then our question to them is, why didn't you do something about it sooner? We don't allow them, necessarily, to have the 40 or—well, we never approved a 40 percent increase, we just don't do it—because we believe the consumer needs to be protected so that they can continue to have the protection of that product, and we're not going to benefit the company because of any mismanagement or poor decisions on their part in terms of pricing.

It's our opinion that, under this model, we would lose the ability to behave that way, and that concerns us.

Thank you, Senator.

[The prepared statement of Ms. Cutter follows:]

Testimony of

Carol Cutter, Chief Deputy Commissioner Health and Legislative Affairs
Indiana Department of Insurance

Before the
United State Senate
Special Committee on Aging

June 3, 2009
2:00 PM

Good afternoon Chairman Kohl, Ranking Member Martinez, and members of the Committee. Thank you for the opportunity to testify today regarding the regulation of long-term care insurance. My name is Carol Cutter, and I am the Chief Deputy Commissioner of Health and Legislative Affairs for the Indiana Department of Insurance. My purpose today is to provide the Committee with the history of the Indiana Long Term Care Partnership Program (ILTCIP).

We believe it is important for the Committee to have detailed information regarding Indiana's experience with long term care partnership products, as you consider any regulatory changes. This program was implemented by then-Governor Evan Bayh in May, 1993. Governor Bayh recognized the need for Indiana residents to assume self-responsibility for funding long term care expenses. He also believed this program would help protect the State of Indiana's Medicaid funds from individuals who could afford to insure, or self-pay with their own assets for long term care costs.

Since it's inception in 1993, ILTCIP has sold more than 45,000 policies covering all types of long term care services including facility-based, assisted living and care at home. 91% of these plans included benefits for all three types of services. Of those more than 45,000 policies, in only 30 times have consumers ultimately exhausted their policy benefits and been forced to apply to Indiana Medicaid for assistance. We have estimated the savings to the state Medicaid program during these years to be in the range of \$10-12 million dollars. The documentation supporting this calculation was discussed in the *Issue Brief* written by Mark E. Meiners, George Mason University, for the Center for Health Care Strategies, Inc. in March of 2009.

There are currently nine insurers writing partnership plans in the state of Indiana. Since January, 2006 there have only been 71 complaints related to ANY long term care insurance contract filed with the Indiana Department of Insurance. Of those, 23 were

rate increase complaints and 45 that involved policy holder service or claims handling issues. Without consideration of all the other non-partnership long-term care policies in existence in Indiana, just out of the 45,000 partnership policies, that represents less than 100th of 1 percent. Our consumer consultants address each complaint individually and assist the consumer in obtaining resolution.

In addition to these consumer protection measures, even more importantly, our department carefully scrutinizes all long term care rates whether for a new product, a renewal, or a rate increase. We are especially fortunate to have had as our consulting actuary for over 15 years, a health actuary who also served the federal government. He was the director of the Division of Medicare Cost Estimates for the Health Care Financing Administration, currently known as Centers for Medicare and Medicaid Services. In that capacity he was responsible for the periodic actuarial valuations for Part A and Part B of the Medicare program.

Within this experience, we have not been persuaded that rate stabilization will be effective in controlling costs for long term care products. In fact, several states have already discussed with us their frustrations regarding the apparent inability of rate stabilization to slow down or reduce rate increases. In our review of the rate stabilization model, our conclusion is that this process restricts Indiana's ability to continue to carefully scrutinize long term care pricing.

In our opinion, the most effective change this Committee and the NAIC could consider would be a mandatory actuarial-level review by each state's Department of Insurance for any long term care product. The reason this would make a dramatic difference is that many states currently do not have either a contracted or in-house actuary to conduct formal reviews. Many states simply accept an actuarial memorandum submitted by the insurer as justification for rate structure. This means those states are not conducting any actuarial review on their own of this information. Many of the actuarial justifications that Indiana receives for long term care rate increases are heavily assumptive driven. For instance, the loss ratio a long term care policy must meet before a rate increase can even be submitted is 60%. This means the insurer has paid out 60% **OR MORE** in claim dollars than the company has collected in premiums **FOR THIS POLICY FORM OVER THE ENTIRE LIFE OF THE PRODUCT SINCE IT'S INCEPTION**. Assumptive driven justifications predict loss ratios into the future not based on incurred claims experience. For instance, an insurer may submit a request for an increase that shows a historical loss ratio of 72%. They will then apply an annual percentage increase to this number, again NOT based on incurred claims experience, and project into the future 10 or 20 years which may exponentially end up at a 1000%

loss ratio. This is why Indiana wants to have the ability to continue our current actuarial review process.

The Committee also needs to be aware of the fact that each of these insurers has to meet reserve capital requirements established by the NAIC in conjunction with the American Academy of Actuaries. In addition to solvency requirements that provide financial protection for consumers, there is also an organization called The National Organization for Life and Health Guarantee Association. This entity will step in if an insurer reaches insolvency and will pay claim benefits under a long term care contract. Therefore the consumer has two levels of protection that provide some benefit of financial stability for their purchase.

Indiana was very pleased when the federal congress passed the Deficit Reduction Act of 2005 which recognizes the need for expansion of long term care partnership programs. With federal and state Medicaid budgets in jeopardy due to long term care costs draining these funds, states should be able to have alternate insurance options to offer their constituents. In Indiana only 3% of Medicaid enrollees are receiving nursing home services but these enrollees consume 21% of the entire state Medicaid budget. As the aging population continues to have a greater need for long term care services, this unsustainable discrepancy will only get worse.

Because of this concern, Governor Mitch Daniels has approved a strong consumer awareness campaign for long term care products in general that will be conducted this fall. Indiana has indeed been fortunate to have two governors, both of whom have seen the need for self-responsibility and protection of tax payer funds.

Thank you for opportunity to appear before the Committee. Hopefully I have provided some positive perspective on Indiana's long term care partnership program. I will now be happy to answer any questions from the Committee.

The CHAIRMAN. Thank you so much, Ms. Cutter.
Mr. Stinson.

**STATEMENT OF THOMAS STINSON, PRESIDENT, GENWORTH
LONG-TERM CARE, GENWORTH FINANCIAL, RICHMOND, VA**

Mr. STINSON. Thank you, Chairman Kohl and Senator Martinez, for giving me the opportunity to testify today on behalf of Genworth Financial.

Genworth provides retirement income, life, long-term care, and mortgage insurance coverage to over 15 million customers in 25 countries. As one of the pioneers of long-term care insurance, we have become a leader in the industry, providing services to over 1.3 million policy holders.

Today, I'd like to speak to you on the following four topics of interest to the committee. Our insurance offerings, including the State Long Term Care Partnership Program; our framework for financial stability; Genworth's views on the intersection of healthcare reform and long-term care financing; and last, some brief comments on our support the legislation proposed by the Chairman.

Long-term care insurance is important for several reasons. It generally provides peace of mind to policyholders and their families. For many Americans, it also represents a critical part of a sound retirement plan, providing quality care and care coordination services, and preserving funding sources for future family needs.

The public/private State partnerships for long-term care are a joint solution, positioning private insurance as the primary payer of long-term care expenses. This program is helping consumers receive needed care, and at the same time allowing States to achieve cost savings to alleviate the already strained Medicaid system.

In fact, the fundamental premise of the Partnership Program works—2009 data indicate that only 1 in 1,000 Partnership-qualified policyholders exhausted the full benefits of their insurance policy, and accessed Medicaid. That means private insurance can be used to preserve and protect the viability of Medicaid.

As these Partnership Programs have now expanded to 30 additional States, we know that most purchasers are from middle-income families. This portion of the population is unlikely to have the considerable assets necessary to self-finance their long-term care needs, but wants to maintain a modest level of assets while receiving quality services.

In addition to the State Partnership Programs, we are proud to participate in the "Own Your Future" public awareness campaign. The campaign helps to educate millions of Americans about the importance of advance planning for their own long-term care needs. We strongly encourage this committee to continue the support of this very important public education and awareness campaign.

Next I would like to discuss the risk management framework that Genworth uses to maintain our financial viability. As the largest and oldest long-term care insurer in America, we take seriously our responsibility to remain strong financially, and to fulfill our commitment to our policyholders. We do so by managing our company within a responsible risk management framework.

In fact, it has allowed us to pay out over \$6.5 billion in long-term care claims for care in nursing homes, assisted living facilities, and in the home. Genworth pays over 95 percent of all of the long-term care insurance claims submitted.

Turning to the intersection of healthcare reform and long-term care financing we believe it is essential that we differentiate acute care from long-term care. Studies show that every American will need acute care during their lifetime, while only half of Americans will need some form of long-term care. So, in exploring policy solutions, a universal solution may be appropriate for acute care, while we believe a more targeted approach would be more prudent for long-term care.

For example, wealthy and many middle-class Americans can either self-finance or purchase private long-term care insurance. Meanwhile, the most vulnerable will be protected by Medicaid. This leaves a fourth, or tip-over portion of the population; they are the segment of the population that has limited income, and thus generally can not include long-term care planning in their overall retirement strategy.

But they can be reached by a targeted program similar to the State Partnership Program, helping them avoid spending down their assets and tipping into Medicaid.

Finally, Mr. Chairman, we commend you on proposing the "Confidence in Long Term Care Act of 2009," legislation that supports consistency of oversight, transparency of information, and ensures the protection of our senior population will provide greater confidence and encourage families to proactively plan for their long-term care needs.

We stand ready to work with you as it moves forward in Committee. Thank you very much.

[The prepared statement of Mr. Stinson follows:]

**U.S. Senate
Special Committee on Aging Hearing
June 3, 2009 at 2:00pm
216 Hart Senate Office Building**

INTRODUCTION

- Chairman Kohl and Committee members, thank you for the opportunity to speak with you today on behalf of Genworth Financial.
- My name is Buck Stinson. I am the President of Insurance Products for Genworth Financial, which includes the Long Term Care insurance business.
- We believe that long term care insurance can be a valuable tool to help protect families from the rising costs of long term care, while at the same time, relieving some of the pressure on an already overburdened Medicaid system.
- Genworth Financial provides retirement income, life, long term care, and mortgage insurance products to more than 15 million customers in 25 countries. As one of the pioneers in long term care insurance, we have become a leader in the industry providing services to over 1.3 million policyholders nationwide.
- Over the last 34 years Genworth has paid a combined total of \$6.6 billion in long term care claims benefits. Today, we pay approximately \$3 million per day in long term care benefits. We are committed to our clients and to the value and importance of comprehensive long term care coverage.
- Today, I would like to speak about four topics that are of interest to both your committee and the public. First, I want to discuss what we offer our policyholders and provide our insights into the success of the State Long Term Care Partnership Program. Next, I would like to briefly discuss the regulatory framework that currently exists to ensure policyholders receive the benefits of their policies when needed, and also provide an overview of the significant consumer protections that are provided for under the National Association of Insurance Commissioners Model Act and Model Regulation. I would then like to discuss Genworth's thoughts on the intersection of healthcare reform and long term care financing, and close with a brief discussion on the legislation proposed by Chairman Kohl.

GENWORTH LONG TERM CARE INSURANCE OFFERINGS

- Before I go into what our company offers, I want to quickly cover the origin of this product and how it has evolved. This product is relatively young when compared to life insurance, which has been around for over 150 years. Long term care insurance was first introduced a little more than thirty years ago. In this short span it has gone through rapid evolution in terms of pricing, design and product features. Policies that were sold in the 70's and 80's provided coverage in nursing homes, which was the primary care at that time. As consumers' needs and the availability of care have changed, so have insurance benefits. Today, our long term care insurance covers care in the home, assisted living facilities, nursing homes, hospice and a variety of other options including adult day care.

Overview of Coverage

- Long term care insurance is important for four reasons: First, it generally provides peace of mind to policyholders and their family in a time of shifting and uncertain economic burdens. Second, it represents a critical part of a sound retirement plan – protecting assets and preserving funding sources for future family needs. In certain cases on the more severe claims, it can also prevent the need to access Medicaid funds. Third, it can serve to increase the number of care options available to policyholders and their families. Finally, care coordination, ongoing care management and other informational resources provide value well beyond the payment of financial benefits.
- Long term care insurance covers expenses for home health care, nursing homes, and assisted living facilities when a policyholder is chronically ill, as defined by the federal HIPAA (Health Insurance Portability and Accountability Act) statute.
- Specifically, a policyholder is chronically ill when they either need assistance with two of six activities of daily living (such as bathing, dressing, and feeding themselves) or they need assistance because of severe cognitive impairment, such as dementia or Alzheimer's disease.

- Forty-eight percent of our claim dollars pay for cognitive impairment and dementia, the majority associated with Alzheimer's disease.
- Today's long term care insurance products also offer care coordination services to develop a plan of care for policyholders, ongoing care management and help in supporting caregivers. For our customers, the policy is not just about avoiding the devastating expense of long term care needs, but also about having access to quality care and informational resources.
- Long term care insurance covers services for chronic conditions that are not generally covered by health insurance or Medicare and may be provided by state Medicaid programs, on a more limited basis, once an individual spends all of their assets and becomes destitute. And unlike Medicaid, which typically only covers Medicaid-eligible institutional care, long term care insurance covers home health care, including the use of informal caregivers.
- Today, the average age of our individual insurance buyer is 57. The average age has rapidly declined over the last decade as more consumers realize the benefit of purchasing coverage at a younger age. With more people interested in long term care at a younger age, we have expanded our product offerings to help provide greater flexibility and affordability.

Group Policies

- Genworth is dedicated to both the individual and group LTCi markets. Between 2005 and 2008, we issued 229,956 individual long term care policies. During this same period we issued 43 group policies with employee sizes ranging from 150 employees/members to over 650,000.
- About 40 percent of people receiving long term care services are under the age of 65. This is one of the reasons why long term care insurance has become a frequently requested employee benefit. Through our group policy, we work with employers to provide their employees with a secure way to help them protect their savings and assets, shield their family and friends from the burden of caregiving, and give them the flexibility to choose where their care will be received.

- Since 2007, we have been the AARP's exclusive provider of long term care insurance, offering our long term care insurance solutions to their more than 40 million members.

Partnership Program

- As way of background, the public-private State Partnerships for Long Term Care program was developed in partnership with the Robert Wood Johnson Foundation and state governments. The program – which allows individuals to purchase a long term care policy and qualify for Medicaid benefits without depleting all of their assets – is helping states achieve cost-savings solutions to alleviate the already strained Medicaid system. The model was first tested in California, New York, Connecticut and Indiana. The success in the original four states helped the program spread to 30 states. Of the 30 states that have filed state Medicaid plan amendments with the Department of Health and Human Services, 28 have been approved and two are pending approval.
- Through the State Partnerships for Long Term Care Program, Genworth is working with states to ensure Americans have the coverage they need should the need arise at some point in life. This program is a true win-win, as consumers are afforded a first layer of protection through a private insurance policy with the flexibility and choice it offers; backed by the state Medicaid program should they exhaust the benefits of their private policy and otherwise qualify for Medicaid benefits.
- As evidenced by the initial four states that have been participating since the program's inception 12 years ago, this program is very effective. For example, as one of the pilot states Connecticut, found that as many as 30 percent of all Partnership participants would have transferred assets to qualify for Medicaid in the absence of the Partnership Program. These individuals represent significant cost savings to the Medicaid program. Conceivably, most dollars paid by a Partnership policy could have been a dollar paid by already-overextended government programs. Therefore, through the Partnership Program, we are delaying or eliminating the need for individuals to access Medicaid early-on for long term care services.
- Genworth played a leading role in implementing the Partnership Programs in the initial four pilot states (New York, Connecticut, Indiana, and California). The Partnerships in

these initial states have taken the form of two models. The dollar-for-dollar model allows people to buy a policy that protects a specified amount of assets, up to the total of benefits received under the policy. The total asset model provides protection for 100 percent of insured's assets in the event that they exhaust their private insurance coverage.

- This beneficial program has helped states and policyholders alike. A 2005 study by the Government Accountability Office (GAO) on the initial Partnership Program states concluded that Medicaid was able to reduce costs because very few policyholders actually exhaust their benefits and become eligible for Medicaid due to the fact that their policies covered most of their long term care needs. In fact, with over 300,555 partnerships qualified policies to date in the original four partnership states, only 315 individuals – less than 1% of individuals – have exhausted benefits and had to use Medicaid.
- Policyholder research conducted for Genworth Financial in 2005 revealed that consumers found the Partnership Program particularly appealing because it combines the benefits and flexibility of private insurance with the backing and safety net of the government. Policy holders are satisfied because they are given payments that reflect the current costs of long term care and are not forced to deplete their own assets. Today, our policies provide individuals with an average daily benefit payment of \$152.00. To put it into perspective, the 2009 daily rate for a semi-private room at a nursing home is \$183.00, the average daily rate for a private bedroom in an assisted living facility is \$93.00 and the average hourly rate for Home Health Aide services is \$18.50.
- In the event an individual does exhaust his or her benefits under their Partnership policy, Genworth has a secure system to notify the individual and the state Medicaid offices. If an insured is nearing the end of his or her policy benefits, they are sent a letter about three to six months prior, notifying him or her that the benefits are nearing exhaustion and providing an estimated date of when the benefits will end, based on prior utilization. Starting in August of this year, state Medicaid agencies, in the second phase of the Partnerships Program, will have access to detailed partnership policyholder information which includes information about policies that are close to exhausting benefits. By maintaining open communication with both the policy holder and the state Medicaid

offices, we are attempting to help individuals gain the best access to long term care and help states save money.

- As these partnership programs develop in more states, the industry has learned that most purchasers are from middle-income families. This portion of the population is unlikely to have the considerable assets necessary to self-finance their long term care needs, but want to maintain a modest level of assets while receiving quality services. In addition, coverage of this nature provides these families with the peace of mind that in the unlikely event that they exhaust their benefits, they could access Medicaid and still maintain assets equal to the long term care insurance benefits they received under their policy. The Partnership program is an excellent example of a public-private approach to America's long term care financing problem that works.

Long Term Care Information Clearing House - Own Your Future

- In addition to the State Partnership Programs, we are happy to participate in the "Own Your Future" public awareness campaign. The campaign helps to educate millions of Americans about the importance of planning for their own long term care needs in advance. We strongly encourage this committee to continue their support for this very important public education and awareness campaign, including support of H.R. 519 that expands and extends future funding for this program.
- The campaign, spearheaded by the U.S. Department of Health and Human Services and funded through the Long Term Care Information Clearing House, works with Governors in states participating in the program to develop a series of mailings to mature Americans explaining long term care events and the government's role in providing funding for long term care.
- The campaign was created by a joint federal-state initiative in 2005 and piloted in five states; Arkansas, Idaho, New Jersey, Nevada and Virginia. The positive consumer response has allowed the program to grow to 19 states across the United States, and additional states have plans to participate in the program in 2009.
- Today, the mailing campaign includes an introductory letter from the Governor, a complimentary Long Term Care Planning Kit which contains state-specific information and

resources. In addition, the Deficit Reduction Act of 2005 provided \$3 million per year over the last five years to fund the National Clearinghouse for Long-Term Care Information (www.longtermcare.gov) which provides comprehensive information about long term care planning, services and financing options, and tools to help people begin the planning process.

- To date, the campaign has received an average response rate of over 9 percent, with Ohio and Pennsylvania having the highest response rates at 21 and 23 percent respectively. More importantly, the campaign has been successful in motivating planning behavior by those who receive the Planning Kit, who are twice as likely to take some planning action such as talking to an agent or financial planner or buying long-term care insurance as those who do not order the Planning Kit.
- Programs like these, which with the support of the state and federal government encourage Americans to more seriously plan for their later years, are very effective because more people take the initiative to plan for a long term care event thereby reducing the reliance on already burdened government programs. This is particularly important when you consider the results of national public opinion research that we commissioned during the last few years that found a majority of Americans incorrectly believe Medicare or private health insurance cover long term care needs. As a result, three out of four consumers indicated they had made no plans to protect themselves or any of their family members.

GENWORTH'S RISK MANAGEMENT FRAMEWORK

- Genworth has developed an innovative product portfolio designed to anticipate the needs of the long term care market, which includes individual, group and combination long term care insurance solutions that are both affordable and provide flexible features and benefits to help satisfy a wide range of customer needs.
- In 2006, Genworth introduced two combination products that combine the features of our comprehensive LTC benefits with traditional life and annuity products to more broadly serve the planning needs of our consumers.

- We have developed these products and services within a strategic framework designed to create a holistic approach to finding the best planning solutions to the long term care issues facing Americans.
- As the largest provider of this important insurance, we appreciate our responsibility in remaining strong financially and in the way we manage our company. There are four primary drivers of economics in a long term care insurance product: Morbidity, Mortality, Investment Yield and Voluntary Lapses. Our experience over the last 34 years has enabled us to price our products with a focus on long term pricing stability, as represented by the fact that we have only had to seek one rate increase, ranging from 8 to 12 percent, on the policies we have issued over the past 34 years.
- Our experience provides unique insights into the costs of long term care and Morbidity trends. In addition, our experience with this line of business and that of the general insurance industry also provides a good basis for predicting Mortality patterns. As a result, we utilize a comprehensive set of underwriting guidelines designed to manage our new business and continue to evolve our underwriting practices to reflect new experience as it emerges.
- Investment Risk Management is an integral part of Genworth's philosophy and we seek to manage multiple types of risk including exposure risk, duration risk, and correlation risk, among others. Dedicated Risk Management professionals ensure that we have the knowledge and expertise to evaluate and manage Genworth's investment portfolio in all market conditions.

NAIC MODEL AND CONSUMER PROTECTIONS

- Genworth's long term care insurance business has grown because we believe in providing our policyholders value, backed by strong consumer protection.
- Long term care insurance is a highly regulated insurance product, which includes extensive requirements designed to address consumer protection. The National Association of Insurance Commissioners (NAIC) has developed a comprehensive Long Term Care Insurance Model Law and Model Regulation. These models are regularly reviewed and updated to ensure consumer protections evolve to keep pace with changes in the market.

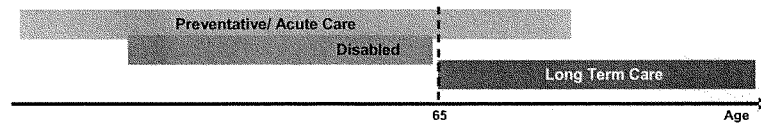
- Genworth supports the adoption NAIC Model Law and Regulation by all states. We believe that this provides consistency and clarity for both consumers and insurance carriers.
- Long term care insurers have historically worked closely with the NAIC to develop these Models, including, for example, enactment of rate stability standards, enhanced disclosure requirements and flexibility for consumers to adjust their policy benefits to meet future needs and reduce costs. In addition, we continue to work towards developing additional laws to protect consumers, including third party review of benefit eligibility denials.
- Our products are sold by dedicated specialists, independent individual and group brokers and financial planners, and through affinity relationships like AARP. All individuals who market our products are subject to state requirements for Life and Health insurance licensing and, in certain states, training requirements. These requirements also require additional continuing education credits for state partnership policies.
- We ensure that individuals thinking about purchasing both our Partnership Program policies and Non-Partnership Program policies receive the necessary information that enables them to understand the features and benefits of the product they intend to purchase. We provide the consumer an outline of coverage that helps the individual understand the benefits and exclusions of the long term care insurance coverage they are purchasing. This information includes, among other things, a statement and personal worksheet which discloses whether the insurer has previously raised rates on its long term care insurance policies, and an inflation protection option. Additionally, agents provide the applicant with a NAIC Shoppers Guide, which helps provide additional information regarding long term care funding and long term care insurance. Once approved, policyholders are issued a policy that details the features, benefits and exclusions of their insurance coverage. In addition, all consumers are given 30 days after receipt to return the policy with a full refund of any premiums paid. We believe the fact that almost all of the policyholders who purchase this valuable coverage retain their policies demonstrates that they both understand and value the protection these policies provide.

LONG TERM CARE FINANCING

- Our company recognizes that the long term care needs of Americans have a significant economic impact on our nation. Generally, long term care financing occurs in one of three ways: through individuals planning for their care needs out of pocket (18 percent), the utilization of private insurance (seven percent) or through accessing Medicaid services (69 percent).
- The Medicaid program only pays after the care recipient has exhausted all of his or her own resources and is financially destitute. Medicare generally does not pay for long term care services, though it does pay for some services at certified healthcare facilities. This coverage, however, typically does not exceed 100 days.
- In 2008, long term care accounted for more than 35 percent of Medicaid expenditures totaling approximately \$100 billion in care costs. If nothing changes, the costs will only increase and put further strain on Medicaid. Reports estimate the costs on Medicaid will increase almost 400% by 2040 costing more than \$380 billion each year. The Congressional Budget Office estimates that the U.S. spends more than \$200 billion annually on long term care, which does not include unpaid services provided by friends and family members. With one in three elderly individuals quickly spending-down to Medicaid, the onset of 77 million baby boomers will only further compound the problem.
- Since 2004, Genworth has surveyed the cost of long term care across the U.S. to provide Americans with a clear understanding of the cost of care in their part of the country. With this knowledge, families can begin to plan prudently for these potential costs. Our 2009 survey covers more than 14,000 nursing homes, assisted living facilities, and home health and adult day health care providers in 331 regions across America. Genworth's Cost of Care Survey found that the average annual rate for a private room at a nursing home grew from \$62,415 in 2005 to \$74,208 in 2009. At this rate, the cost of care for a private room is expected to exceed \$270,000 a year by 2050 when the nation's youngest baby boomers will reach their mid-70s.
- I reference these numbers as the elderly population is increasing at an unprecedented rate and Medicare and Medicaid are emerging as unsustainable mechanisms in terms of paying for the cost of long term care. As the Baby Boomers reach their older years,

few are prepared, or aware of the increasing costs of long term care. However, coupling long term care with acute health care reform will not solve the problem.

- As an alternative approach, we would recommend more efficient solutions to sustaining Medicaid that do not attempt to solve the long term care financing needs for 300 million Americans who do not have a long term care solution today. Our recommendation is taking a more targeted approach that is intended to focus on the true size and scope of the problem. This approach includes identifying the targeted group that can best benefit from a private-public partnership thereby more efficiently and effectively resolving the strain long term care has on publically funded programs.
- To understand the scope of the problem and how to target this select group, we must first understand the differences between long term care, acute care and disability care and the primary issues in each of these areas.



Types Of Care	Acute Care	Disabled & Chronic Care	Long Term Care
What It Is	Short-term medical treatment, for having an acute illness or injury	Ongoing care due to Physical/ Mental illness or injury	Care required as a function of aging
% of Population With Need	100% will use during their lifetime	6-9% of the working age population	~50-60% will need during their lifetime
Key Payers	<ul style="list-style-type: none"> Pvt. Insurance 52% Public Programs 17% 	<ul style="list-style-type: none"> Pvt. Insurance 49% Public Programs 38% 	<ul style="list-style-type: none"> Pvt. Insurance 7% Public Programs 69%
Key Issues	<ul style="list-style-type: none"> Large % of Uninsureds Rising Cost 	<ul style="list-style-type: none"> Number of Uninsureds Burden On Families 	<ul style="list-style-type: none"> Strain On Medicaid Aging Demographic
Reform Focus	<ul style="list-style-type: none"> Cost Access 	<ul style="list-style-type: none"> Cost Access 	<ul style="list-style-type: none"> Strain on Medicaid

- First, we must differentiate acute care from long term care. Studies show that every American will need acute care during their lifetime, while only half of Americans will need some form of long term care. The wealthy and middle-class Americans that require long term care will not rely on government funding; rather they will either self-finance or purchase private long term care insurance. Meanwhile the truly

vulnerable or indigent are Medicaid eligible. This leaves a fourth or “tip-over” portion of the population. They are the segment of the population that rest on the cusp of Medicaid eligibility, yet have limited income and thus generally do not include long term care planning in their overall retirement strategy. Moreover, this “tip-over” portion of the population is much more likely to become Medicaid eligible if it suffers a long term care event.

- Second, we must retain a safety net to provide long term care funding for this target group or the “tip-over” population. By developing solutions similar to the state Partnership Programs, we can prevent this precarious population from spending-down into Medicaid. Moreover, meaningful benefits; including comprehensive in-home benefits and daily benefits that reflect actual utilization should be available to consumers who truly need assistance, strengthening existing eligibility controls.
- We believe that this targeted approach works best when the government and private industry work together for the benefit of consumers. As such, we would recommend a program, similar to the Partnership Programs that exist today, that incent individuals to prepare and plan for a future long term event. Under this proposal, individuals would be incented to purchase private long term care insurance protection, with the understanding that in the unlikely event that they exhaust their private insurance benefits, the government programs that exist today would be available as a catastrophic “backstop” should they continue to need care.
- This targeted population represents 29 million: 13 million over the age of 50 in the \$20,000-\$30,000 income bracket plus 16 million in the \$30,000-\$50,000 bracket. We estimate that this targeted approach will save the Medicaid program \$19 billion by 2030 freeing up Medicaid to focus on the intended recipients and reduce its financial burden. This safety net should address both the cost and access barriers, thus a means-tested premium should be considered and simplified underwriting take place.
- Lastly, we recognize continued education and awareness among those able to self fund their long term care needs should be revitalized. With the first wave of the 77 million Baby Boomers beginning to retire, is essential that we provide an alternative to the already stressed Medicare and Medicaid system. Other proposals provide questionable sustainability and insufficient benefit levels to cover the increasing costs

of long term care. However, by changing the equation and encouraging proactive planning for long term care needs through private insurance, we can empower Americans to reduce both their and the nation's dependence on entitlement programs.

PROPOSED LEGISLATION

- Before I conclude, I would like to comment on the Confidence in Long Term Care Insurance Act of 2009. Genworth Financial wholeheartedly appreciates the intent of this legislation, which suggests to us a profound recognition of the important role of private long term care insurance. In addition, we support the Chairman's efforts to ensure adequate oversight and monitoring of the private market and its state regulators to continue to promote consumer confidence as the market fulfills its obligation to protect consumers when they purchase a policy and at the moment of truth, when they need to access their policy benefits.
- Let me assure you that Genworth Financial became the market leader in this business because we share the Committee's interest in the consumer. As evidenced by our strong claims paying record, we feel that we are in business for one reason - to provide quality care options to our policyholders if and when they need them.
- Monitoring the continued success of the State Partnerships Program, expanding the National Clearinghouse for Long Term Care, and working closely with the NAIC are all activities that Genworth supports.
- As the Chairman advances this legislation, please allow me to extend an offer to provide data or other assistance and expertise if you find it helpful.

CONCLUSION

- Thank you Chairman Kohl and members of the Senate Special Committee on Aging for the opportunity to testify on this very important and relevant issue.

The CHAIRMAN. Thank you very much, Mr. Stinson.
Finally, Bonnie Burns.

STATEMENT OF BONNIE BURNS, TRAINING AND POLICY SPECIALIST, CALIFORNIA HEALTH ADVOCATES, SCOTTS VALLEY, CA

Ms. BURNS. Thank you, Chairman Kohl, and thank you, Ranking Member Martinez, for giving me the opportunity to testify at this hearing today. We appreciate the committee's interest in protecting consumers, and increasing the quality of long-term care insurance products.

As you noted, Senator Kohl, long-term care is unpredictable, expensive, uncoordinated, and not integrated with the healthcare system. As part of health care reform we would like to recommend that seniors, elders and people with disabilities, should have a seamless transition to long-term care services, coordination with medical care, and a support system to help them find and access the services that are best suited to their needs.

Long-term care insurance pays for a very expensive kind of care that over half of all people 65 and older may need at some point during their lifetime. So, it's not unreasonable to expect that insurance coverage for this kind of care would be expensive as well.

However, competition for this product often depends more on the size of a premium than on the actual benefits, because these products are so difficult to compare with each other. Many policymakers believe that if long-term care insurance were more widely spread, it would result in substantial Medicaid savings, but we won't know if that's true for many years. In the meantime, Medicaid savings will be part of every marketing effort to sell this type of product.

Long-term care insurance is a niche product; poor people can't afford it, and don't need it, while higher income people can afford to transfer their risk to an insurance company if they are in good health. But the middle class is most at risk for spending down to Medicaid, and those individuals may pay more in total premiums than they have in non-housing assets, or than the benefits that they will receive. They may buy insufficient benefits and build into a policy a larger co-payment amount than they expect as the cost of care increases.

Failing to buy inflation protection will compound this problem, leaving a consumer with only a small amount of their future care covered by an insurance payment. Buying an insufficient benefit, and failing to buy inflation protection, are decisions that are made when the policy is purchased, and often trades off the cost of those benefits for an affordable premium.

Whether a policy will perform as expected decades later, depends on the quality of the product purchased, whether the policy benefits can keep up with inflation, or lose value each year, whether the premiums consumers initially agreed to pay remain stable over several decades, and whether the individual still has those benefits decades later when care is needed. If the goal is to have more people buy a commercial product to pay for long-term care and relieve pressure on State Medicaid programs, then the benefits must cover a substantial amount of the cost of care when it's needed.

A long-term care insurance policy is not without its own risks. Recently a flurry of rate increases have been imposed, including a pending rate increase for the long-term care insurance program for the Federal family, and even by companies that had never imposed one before.

Here are two examples: Mr. B.'s premium jumped from \$1,874 annually, to \$4,050. He has paid just short of \$31,000 in premiums during the last 11 years and he's now 80 years old.

Mrs. C. is also 80. She saw her annual premium jump to \$7,453.56. She has paid the company \$47,309 in premiums during the last 11 years. It remains to be seen whether the NAIC's rate stability requirements will result in less premium volatility in the future for consumers buying these products today.

In the meantime, long-term care insurance policies will continue to be marketed as level-premium products, with agents telling consumers that their premiums can't be increased based on their own age or health. While this is true, this misleads consumers about the potential for future rate increases when a company's claims experience is worse than expected, or their investment goals are not met.

A Partnership program, in theory, allows consumers to shelter certain amounts of their personal assets from the State Medicaid program by buying a long-term care insurance policy that protects one dollar of assets for each dollar of insurance benefits paid out.

A 2007 report found that Partnership policies were mostly purchased by upper-middle income and higher-income people who were less likely to qualify for Medicaid. The majority of those purchasers had assets greater than \$350,000 and annual incomes of \$60,000 or more.

Insurance companies and their sales agents clearly have a compelling and valuable marketing advantage with the Partnership program. An insurance policy endorsed by the State makes it instantly both more attractive and credible. Sales opportunities for these products begin immediately while the effect, if any, on State Medicaid programs will not be known for many years.

Substantial numbers of older consumers can not qualify for coverage because of their health, or they can't afford long-term care insurance. Convinced that the high premium cost is the greatest barrier to buying long-term care insurance, companies often offer less expensive base policies to working-age consumers in the group market with the cost of inflation protection pushed out into future years through a guaranteed future purchase option.

Seventy-two percent of group purchasers select a future purchase option, an option that provides guaranteed insurability to exercise this option later at higher attained-age rates. This is also a limited option that can only be rejected a few times before the offer expires completely.

Alarmingly, only 37 percent of the future purchase options that were extended in 2008 to people with group coverage were accepted, yet this option leaves consumers at risk of steadily building an unaffordable co-payment liability that will come due when they need care.

The Federal Government established a regulatory floor of standards and consumer protections, first with HIPPA, and then in the

Deficit Reduction Act (DRA) for the Partnership policies. Federal law could go further by requiring NAIC to periodically review and incorporate the strongest standards and consumer protections that are found in any State. Federal law could establish a working group composed of regulators, industry and consumer groups to incorporate those standards into the NAIC models, and require a periodic Federal review to decide when recent the NAIC standards should be incorporated into Federal law. Such a process would capture the best of State laws and enhance Federal law. I understand you've done some of that in the bill that you're introducing today.

It's important to remember that long-term care insurance is an investment not just in the product, but in the company selling it. Making sure that adequate consumer protections are in place will help ensure that insurance companies and their products live up to their promises in the future.

Thank you for the opportunity to testify today on this important topic.

[The prepared statement of Ms. Burns follows:]



CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

TESTIMONY of CALIFORNIA HEALTH ADVOCATES

Gambling on Consumer Ignorance: Comprehensive Consumer Protections and Regulatory Scrutiny Are Required To Protect Purchasers of Long-Term Care Insurance Products

**Senate Special Committee on Aging Hearing
Private Insurance and Long-Term Care
Hart Senate Office Building, Room 216
June 3, 2009
Washington D.C.**

INTRODUCTION

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of California's Medicare beneficiaries. We provide support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAP). HICAP is California's federally funded State Health Insurance Assistance Program (SHIP) that assists California's Medicare beneficiaries and their families. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare, Medigap, and long-term care. Our experience with many health and insurance related issues is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting older consumers and their families.

In 1992 I served on the Consumer Standards Working Group, the founding committee for developing the Partnership for Long-Term Care in California.¹ I also served as a funded consumer representative to the National Association of Insurance Commissioners (NAIC) from 1991 to 2006 where I successfully advocated for many of the consumer protections added to the NAIC Model Act and Regulation for Long-Term Care Insurance, some of which reflect specific protections in California law. I have testified before Congress on consumer issues pertaining to long-term care insurance beginning in the late 1980s, and most recently before the House Energy and Commerce Subcommittee on Oversight and Investigations on July 24, 2008, on long-term care insurance premium increases and denied claims.

¹ The authorizing legislation for the California Partnership for Long-Term Care established the Long-Term Care Task Force, an inter-agency workgroup of staff from the state agencies that had responsibilities for implementing the Partnership to oversee the design and implementation of the demonstration. In April 1992, the Long-Term Care Task Force established the Consumer Standards Working Group to develop advisory recommendations regarding the product, and consumer standards that should apply to all insurance policies approved by the Partnership.

Thank you for the opportunity to comment at today's hearing. We appreciate the committee's interest in protecting purchasers and increasing the quality of long-term care insurance products.

I. Long-Term Care and Health Care Reform

Long-term care is unpredictable. Few people can predict what condition will trigger a need for care decades later, the range or intensity of services they may need, or, whether institutional care will be required because of the severity of their condition. Planning for long-term care is complicated because of the unpredictable fact of whether it will ever be needed, and the wide array of potential services included in long-term care. Institutional care, and home and community based care is often used in combination with acute care services and ongoing medical care. Some long-term care services are provided through public programs with differing eligibility requirements, and some services are privately paid requiring large monthly payments.

Long-term care is expensive. It is the primary cause of catastrophic out-of-pocket spending, often leading to personal impoverishment and subsequent reliance on state Medicaid programs.² Middle-income people with modest amounts of assets have the greatest risk of future financial impoverishment when faced with the high cost of Alzheimer's disease or other conditions that may require years of care.³ In 2008, the national average cost of nursing home care was \$69,715 annually, while assisted living care averaged \$36,372 annually.⁴ These are costs that few families can afford.

Long-term care services are fragmented and uncoordinated. When people require long-term care services, they and their family members are met with a fragmented system of care facilities, community services, and providers. No roadmap exists to easily connect people with the services they need; no coordinated system helps arrange and monitor their care, or evaluate and adjust services when care needs change. Such coordination of care only exists if a family has the means to hire a geriatric care manager,⁵ and one is available in their community. Each family must patch together their own set of services based on whatever information they have or are able to find in their own community, or the community of their family member.

² "About \$193 billion was spent nationwide on long-term care services in 2004, including nursing home care and other assisted-living services. Most of this care was financed by government programs, primarily Medicaid....." Government Accountability Office 6/30/08 letter to Congressional requesters, "Long-Term Care Insurance: Oversight of Rate Setting and Claims Settlement Practices," GAO-08-712.

³ Miners, Mark, PhD, George Mason University, "Medicaid Eligibility Issues for Long-Term Care Partnership Programs," Issue Brief for Centers for Health Care Strategies, Inc., March 2008.

⁴ The MetLife Market Survey of Nursing Home and Assisted Living Costs, October 2008, <http://www.metlife.com/assets/cao/nmi/publications/studies/mmi-studies-2008-nhal-costs.pdf>.

⁵ Geriatric care management is generally defined as a service that assesses an individual's medical and social service needs, and then coordinates assistance from paid service providers and unpaid help from family and friends to enable persons with disabilities to live with as much independence as possible, live in one's home with assistance, or to assess other living arrangements such as supportive housing or assisted living facilities. See the National Association of Professional Geriatric Care Managers website: <http://www.caremanager.org>.

Long-term care is part of health care reform. As Congress wrestles with health care reform legislators should focus on creating an integrated and coordinated system of care and services, both medical and non-medical, which families can easily access in their local communities. Services should be easy to find, arrange, and monitor. Geriatric care management and coordination should be an integral part of long-term care services to allow older Americans to live as independently as possible in the least restrictive environment. Elders and people with disabilities who need long-term care should have a seamless transition to long-term care services, coordination with medical care, and a support system to help them find and access the services best suited to their needs.

II. Financing Long-Term Care

Long-term care today is largely financed through private payment with people using their personal income and assets to pay for care, or purchasing insurance that will pay for care later. State Medicaid programs pay when people's income is insufficient to pay for care and their asset are mostly gone. Increasingly elders are being sold reverse mortgages, the proceeds of which can pay for care, or more recently, be used to finance the cost of a long-term care insurance policy. Others move into arrangements such as continuing care retirement communities that combine housing with a continuum of long-term care services they can use as needed.

Long-term care insurance products are sold to individuals, or to members of a group through an association or faith-based organization's sponsorship, or through the sponsorship of a private or public employer. The federal government created the Federal Long-Term Care Insurance Program (FLTCIP) for the federal family of employees, active duty military, retirees, and qualified family members in 2002, and many states also offer access to long-term care insurance to public employees. Few employers, including the federal government, pay any part of the premium for this type of insurance.

Some insurance products provide benefits only for long-term care, while others are sold as riders to life insurance, annuities, and disability policies. Life insurance policies and annuities are complex financial instruments on their own. Adding long-term care benefits to these products increases the complexity and makes them even more difficult to compare with each other, or with policies that only pay for long-term care.

Long-term care insurance was formerly sold only to people in their 60s and 70s, yet more recently it has been marketed and sold to younger people through the employer and association group market who will need to pay premiums for several decades to cover the cost of care in their later years.⁶

Amid concerns about increasing Medicaid payments for long-term care services and the growing numbers of people who exhaust their assets and turn to Medicaid for help, Congress enacted the Deficit Reduction Act (DRA).⁷

⁶ The cost of long-term care insurance for working age people often competes with the cost of other necessary protections such as disability income, retirement savings, and life insurance.

⁷ Deficit Reduction Act of 2005 (DRA), PL 109-171.

The DRA allows states to ignore assets above the Medicaid limit and waive estate recovery of certain assets when people buy long-term care insurance policies that meet federal requirements as part of a public-private Partnership program recently extended to all states by the DRA.⁸ This arrangement is often referred to as “asset protection,” a formal agreement between the state Medicaid program, the insurer issuing the policy, and the purchaser.

Long-term care insurance is an investment in the product, and in the company selling it. If the goal is to have more people buy commercial products to pay for long-term care and relieve pressure on state Medicaid programs, benefits have to be in place when care is needed and must cover a substantial amount of the cost. Making sure adequate consumer protections are in place will help ensure that policies live up to their promises. Whether a policy will perform as expected decades later depends on the quality of the product purchased, whether policy benefits keep up with inflation or lose value each year, whether the premiums consumers initially agreed to pay remain stable over several decades, and whether the individual still has those benefits decades later when care is needed.

III. Protecting Consumers

If consumers are to be adequately protected when buying long-term care insurance then members of Congress must enact the strongest protections possible. The National Association of Insurance Commissioners (NAIC) Model Act for Long-Term Care Insurance and Model Regulation to implement the Model Act serve as an advisory regulatory foundation for state laws and regulation.⁹ Congress selected certain provisions of the NAIC Models to be national standards for tax-qualified policies in the Health Insurance Portability and Accountability Act (HIPAA),¹⁰ and for Partnership policies authorized by the DRA.¹¹

However, national standards for long term-care insurance products should not be based on a compilation of the lowest common denominator that can be reached by the NAIC, but on the strictest standards enacted by the individual states. The NAIC should be required to annually survey the states and incorporate into the Model Act and Regulation biannually any provisions adopted by other states that provide stronger or more meaningful standards and protections than the existing Model Act and Regulation provide.

For example, California, and perhaps other states as well, have enacted a number of standards and consumer protections that are not included in the NAIC Models and should be included in national standards for these products.

⁸ PL 109-171. See Section 6021 that amends Section 1917(b) of the Social Security Act to provide for Qualified State Long-term care Insurance Partnership programs. See: <http://www.dehpg.net/LTCPartnership/map.aspx>.

⁹ The NAIC adopted the first Model Act for Long-Term Care insurance in 1986 followed by the Model Regulation in 1987.

¹⁰ The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191).

¹¹ P. L. 109-171.

A selection of requirements for every long-term care insurance contract in California:

- 6 required categories of services, such as personal care and homemaker services, in every home care benefit to ensure a comprehensive benefit, and consistency among products.¹²
- Nursing home benefits can't be limited to room and board charges only, and must include all long-term care services delivered in that setting. This rule ensures that policyholders can receive benefits for all appropriate services delivered in a nursing home.¹³
- Nursing home, assisted living, and home care benefits can't be separately limited by duration, such as 4 years of nursing home care with only 1 year of home care. This rule ensures that policyholders can receive benefits in the setting of their choice.¹⁴
- Maximum policy benefits must be expressed in total dollar amounts, and must be interchangeable and available for all covered services (except those with express annual limits such as respite care) to ensure the greatest flexibility in receiving and paying for care.¹⁵
- Benefits must begin for all covered services when a person is unable to do 2 of 6 Activities of Daily Living (ADLs) or has cognitive impairment, to ensure that consumers are not restricted to one kind of care and can choose the most appropriate place to their receive care.¹⁶
- Assisted living benefits must be no less than 70 percent of a nursing home benefit and must be paid in any licensed facility in California. Companies must use a verbatim definition for such facilities outside the state. These requirements ensure that benefits will be paid in every place that is licensed to provide assisted living care in California, and increases the likelihood of payment outside the state.^{17,18}
- Ancillary benefits such as home modification with a known market value must be at least 5 times the daily benefit to prevent the inclusion of illusory benefits in long-term care insurance contracts.¹⁹

¹² California Insurance Code §10232.9.

¹³ California Insurance Code §10232.95.

¹⁴ California Insurance Code §10232.93.

¹⁵ California Insurance Code §10232.93.

¹⁶ California Insurance Code §101232.8, §10232.92, and §10232.97.

¹⁷ California Insurance Code §10232.92.

¹⁸ State regulation of assisted living facilities varies across the country and there is no consistent definition of these places of care to ensure that assisted living benefits will be paid in any facility advertising or providing these services.

¹⁹ California Insurance Code §10233.2(f).

A selection of consumer protections required in California:

- Every Outline of Coverage for long-term care insurance must include a notice of the availability of HICAP²⁰ services and their toll-free number to ensure that consumers have independent, unbiased assistance in choosing benefits and coverage.²¹
- Agents have a statutory duty of honesty, good faith, and fair dealing to ensure that consumers are treated honestly and fairly.²²
- Agents must complete 8 hours of training specific to long-term care before marketing or selling long-term care insurance, and must complete an additional 8 hours of long-term care insurance training during each 2-year licensing period thereafter. Agents selling Partnership policies must have a separate 8-hour training specific to the Partnership in a live classroom setting, and an additional 8 hours in a live classroom setting during each 2-year licensing period.²³ Adequate training is necessary to ensure agents fully understand long-term care and the connection between a commercial insurance product and the state's Medicaid program.²⁴

Incorporating these standards, along with those required in other states, into the NAIC Model Regulation would increase the quality of products and consumer protections across the country. However, there are many other issues that have neither been addressed by states nor by the NAIC. One example is the illusory nature of an “alternate plan of care” benefit that purports to be adaptable to future care needs.

This benefit promises that when care is needed the company may consider paying benefits in an “alternative setting” (which isn’t clearly defined), or for benefits not covered under the policy. Yet exercising this option is completely at the discretion of the company, which, as shown by at least one company in the example below, may make this benefit illusory.

Example of a failure to provide alternate care or services:

Mr. and Mrs. M replaced their existing AMEX long-term care policies in 1988 with 2 new policies from Continental Casualty Company specifically because the new policies included a benefit for an alternative plan of care in addition to benefits for nursing home care. These 2 highly educated elders believed the benefit described in the new policy was superior to their existing policies, and would allow them the flexibility to receive benefits in whatever setting best met their needs, an impression reinforced by the policy language and the agent who sold them the policy.

²⁰ California’s Health Insurance Counseling and Advocacy Programs (HICAP) is California’s federally funded State Health Insurance Assistance Program (SHIP).

²¹ California Insurance Code §10233.5h(13).

²² California Insurance Code §10234.8.

²³ California Insurance Code §10234.93a(4); Cal. Code Regs., tit. 22, §58056.

²⁴ Both the California Department of Insurance and the Partnership program design a training outline and approve the courses and trainers who teach those courses.

Eighty-nine year old Mr. M recently needed assistance in caring for his wife who has dementia, and filed a claim for the policy's long-term care benefits. The claim was denied with the explanation that benefits would only be paid when Mrs. M, now 86 years old, is confined to a nursing home.

Mr. and Mrs. M have paid approximately \$98,000 in premiums for their 2 policies since 1988 and will apparently receive no benefits unless they each enter a nursing home, regardless of the alternate plan of care promise made to them.²⁵ In the meantime, Mr. M continues trying to provide care for his wife at home, adamantly refusing to send her away to a nursing home. Recently, a lawsuit was filed by a private attorney on their behalf to force the company to live up to its promise. A previous lawsuit against the company on the same issue was resolved with a confidential settlement.

The NAIC Model should address vague promises of future benefit adaptation to ensure that consumers will have coverage when they need it, and coverage that adapts to the evolving environment of long-term care services.

IV. Premium Stability

When consumers buy an insurance product to pay for prospective care years or even decades later they are buying a promise of benefits in an uncertain future. Long-term care insurance is expensive because the cost of care is high and many people need it late in life, and often for long periods of time.

Insurance to cover these costs is pre-funded by collecting enough premiums in the early years to build adequate reserves for claims in later years, although none of the built up cash reserves in these policies are available to the policyholder unless they purchased a specific additional and expensive nonforfeiture benefit.²⁶ When this type of insurance is not properly priced, with less premium collected than needed to build appropriate reserves, policyholders will inevitably pay the bill later with large, and often multiple premium increases. When the deficit between claims and reserves grows too large and a company becomes financially unstable, the state insurance department where the company is located may be forced to seize it and take it under state supervision. This was recently the case with Penn Treaty Network America Insurance Company in Pennsylvania.²⁷

During the 1990s long-term care insurance was seen as a growth product with more than 100 companies competing for the attention of consumers who were healthy enough to qualify for coverage, and wealthy enough to pay for it. Companies often competed for consumers on price and features, while competing for brokers and agents by offering high commissions, expedited underwriting, and quick issuance.

²⁵ California law has no specific requirements related to an alternate plan of care, and the California insurance Commissioner has no authority to order a company to pay a disputed claim.

²⁶ Life insurance presents a similar pattern of low losses in the early years and higher losses later. To compensate "whole life," life insurance products build an internal cash value over time that can be taken out in the form of a loan or taken in cash when lapsing the policy.

²⁷ See, e.g.: <http://www.ins.state.pa.us/ins/cwp/view.asp?a=1285&q=549650>.

Some companies may have under-priced their policies knowing they could rely on increasing premiums later if their losses exceeded a statutory limit. A 2008 report by the GAO noted that some state regulators confirmed that mistakes in pricing older policies have played a significant role in rate increases that have occurred in those policies.²⁸

When establishing the price of a long-term care policy, companies make assumptions about a number of factors, including: the number of claims that will be filed and when; the duration and cost of those claims; how many people will drop their policies due to death or other reasons; and the amount of interest the company will earn on collected premiums. The true cost of claims develops over many years, after policies are sold. Pricing assumptions require careful analysis by a qualified actuary of a state insurance department to ensure that policies are fairly priced, and that consumers will not be subjected to increases that may price them out of their coverage later due to unrealistic assumptions in any category.

In most states companies are permitted to seek a rate increase when projected claims costs are expected to reach more than 60 percent of the premiums collected over the life of the policy form, unless a policy was issued in a state after the effective date the state changed its law or regulation. Under-pricing sometimes takes 10 to 15 years to become apparent, but can have profound consequences for consumers who are often in their 70s and 80s when rate increases are applied, leaving them with few good options. In most cases these elders have paid substantial amounts of premiums over many years.

Two of the most aggressive retailers of long-term care insurance during the 1990s have each sought enormous rate increases; in 2007 Penn Treaty Network America filed for a 73 percent rate increase in Indiana, and various amounts in other states, and Conseco Senior Health filed for a nationwide 40 percent increase this year. Neither request was the first time these companies have imposed rate increases. The 2 cases below illustrate dramatic increases compared to the initial premiums these elders agreed to pay.

- Mr. and Mrs. B each bought a nursing home only policy from Penn Treaty in 1998. Mrs. B, then age 65, bought coverage for 4 years with a \$110 daily nursing home benefit and 5 percent compounded inflation protection. Mr. B, then age 69, bought the same coverage for 2 years. In 2009 they both received notices of a rate increase.
 - Mrs. B's premium jumped from **\$1,570** annually to **\$3,020** at her current age of 76 years. She has paid \$17,903 during the last 11 years.
 - Mr. B's premium jumped from **\$1,874** annually to **\$4,050** at his current age of 80 years. He has paid \$30,744 during the last 11 years.
- Mrs. C, age 80, received a letter from Penn Treaty on March 7, 2009 notifying her of a 21 percent increase and a new monthly premium of \$512.55.

²⁸ Government Accountability Office, Long-Term Care Insurance: Oversight of Rate Setting and Claims Settlement Practices, GAO-08-712.

The letter noted that the company had requested a *53 percent increase*, and that they would be filing an additional request for the difference between the 21 percent approved by the state insurance department and the 53 percent they had originally requested. On April 23, 2009 Mrs. C received yet another letter notifying her of another rate increase and a new monthly premium of \$621.12.

- Her annual premium is **now \$7,453.56**, an astonishing amount for the policy she purchased in 1998, just 11 years ago. She has paid \$47,309 in premiums during the last 11 years.

These policyholders each had the right to lapse their policy and retain the premiums they had paid in future paid-up benefits, known as "contingent benefit on lapse," or CBoL. However, each of them chose to reduce their policy benefits instead, in return for a lower premium increase. That decision may actually leave them with less benefits in the future than if they had taken CBoL since they have agreed to a reduced amount of coverage. For instance, if they agreed to a reduction in the daily benefit amount, the reduced daily benefit amount would be the benefit available to them for each day of paid-up coverage if they are ever able to exercise CBoL in the future, and not the amount they originally purchased.

Conversely, rate increases and contingent benefit on lapse may actually benefit companies more than consumers if it ultimately reduces the number of insured persons and the company's exposure to future claims.²⁹ And, if it forces policyholders with lifetime or unlimited benefits to reduce their coverage to a specific number of years, it also limits a company's claims exposure to a reduced number of years.

Although the NAIC adopted initial rate stability in Section 10 of the Model, and premium increase restrictions in Section 20, only half the states have adopted these requirements, and only policies issued in a state after the effective date of that change are required to comply with them. California adopted a similar requirement in 2000, but added some additional requirements:

Initial rate filings and requests for rate increases in California:

- Rate filings submitted to the department must be reviewed by a qualified actuary with no less than 5 years experience in pricing long-term care insurance³⁰
- If an issuer requests a rate increase greater than 15 percent on a policy form approved under the new law, it must pool all its long-term care business before calculating the need for a premium increase³¹

²⁹ The Bankers Life unit is reporting an \$11 million increase in earnings from the long-term care block as a result of "the release of liabilities for insurance products on lapsed policies and policy owner benefit reductions following recent rate increases, partially offset by an increase in incurred claims." See article by NU ONLINE NEWS SERVICE published 5/15/2009. Accessed on 5/19/09 at <http://www.lifeandhealthinsurancenews.com/news/2009/5/Pages/Earnings-Conseco-NFP-Others.aspx>

³⁰ California Insurance Code §10236.11(a) and §10236.12.

³¹ California Insurance Code §10236.14(d).

It will take years to prove whether or not the NAIC rate stability requirements will stabilize long-term care insurance premiums despite moderately adverse conditions. However, the Closed Block Sub-group of the NAIC Accident and Health Working Group is conducting a state survey to collect rate increase data both before and, if applicable, after the effective date of rate stabilization in a state. The survey information collected may prove helpful in understanding whether further work is needed on rate stability.

V. Making Premiums Cheaper In The Group Market

Long-term care insurance can be purchased in the individual market or through the group market, which includes large and small employers, public and private employers, and association groups and faith-based organizations. Large employers may pay some of the premium and allow every active employee to enroll without health underwriting. A small employer may only sponsor coverage that is sold to its employees with or without medical underwriting and with or without paying any part of the premium. Association or faith-based groups may sponsor or offer long-term care coverage to their members. The policies sold in the group market may have been approved in the state where they are being sold, or approved in another state where the group is headquartered and the master policy is issued.

Competition, and ultimately market share, for the long-term care insurance industry is often based more on the cost of a premium than actual benefits. Convinced that the price of long-term care insurance policies must be lowered to entice consumers to buy it, companies have begun offering stripped down, less expensive coverage in the group market that also includes modifications made to traditional benefits. In some cases small employers may employ an executive carve-out to provide Cadillac coverage to owners, while offering stripped down base policies to employees who can, if they choose, add additional benefits at extra cost.

These pricing strategies allow insurers to offer long-term care insurance as an additional benefit to employees or group members at very little cost. Policies sold in the group market may also provide insurers with the lapse rates they were unable to achieve in the individual market since working age people are less likely to keep these policies throughout their working lives and into their 80's when benefits are most likely to be used. Some benefit modifications in the group products have migrated to the individual market allowing companies to offer policies at lower premium cost.

Younger policyholders often have little knowledge of long-term care services. Employees or members are often offered the opportunity to upgrade their base policy by adding missing features such as inflation protection, but may not understand the significance of those missing features or be willing to pay the higher cost of adding them to their policy. Some examples of modified benefits are listed below:

- Offering the right to purchase inflation protection at a later date, and at an additional premium cost based on the current age of the policyholder at the time the additional benefit is added.

This future purchase option (FPO), selected by 72 percent of group purchasers,³² is a thinly disguised effort to push the cost of inflation protection into the future, and simply provides guaranteed insurability for the future purchase of this benefit at attained age rates. In addition, an FPO is a limited option that can only be rejected a few times before the offer expires. Buying built-in inflation protection at the time of purchase would add 100 percent to 300 percent to the premium, an amount few working age people are willing to pay.³³ Yet, an FPO leaves consumers at risk for steadily building an unaffordable co-payment liability that will come due when they need care. Alarming, only 37 percent of FPO options extended in 2008 to people with group coverage were accepted.³⁴

- Offering a policy that does not include a waiver of premium but instead the waiver is offered at extra premium cost. Without a premium waiver, a policyholder must still continue to pay an annual premium, whatever the cost, even when they are receiving care and collecting benefits. Without a premium waiver some people might need to use some of the benefit they receive to pay the premium, thereby reducing the benefit amount available to pay for their care.
- Separating the cost of the housing component of assisted living and paying only for direct assisted living services, resulting in a benefit similar to a home care benefit that fails to cover the expense of living in an assisted living facility. This benefit design allows companies to reduce the premium cost of an assisted living benefit, the result of which is seldom obvious to purchasers.
- Offering an insufficient daily benefit amount without inflation protection that is less than 80 percent of current costs, resulting in policyholders having a large and growing out-of-pocket cost when care is needed later. This benefit design transfers the bulk of the cost of care to the policyholder, who pays the difference between the cost of care and the benefits they receive. In 2008, 42 percent of group purchasers bought a daily benefit of \$150 or less, and 72 percent of group purchasers choose a future purchase option for inflation protection.³⁵ This is a troubling combination when claims are not expected for 20 or more years. The daily benefit amount available to pay for care may only be a small portion of the actual cost of care at that time care is needed.
- Charging premiums that automatically increase over time on a scheduled basis until age 65, known as attained age rating, increasing the chance that policies will lapse as the cost of coverage increases with age.

³² The 2009 Source Book, the American Association of Long-Term Care Insurance.

³³ General Accountability Office (GAO) noted in its May 2007 Report, "Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings," that the primary reason people don't buy Partnership policies that include inflation protection is due to the increased cost of that benefit.

³⁴ The 2009 Sourcebook, American Association for Long-Term Care Insurance.

³⁵ The 2009 Sourcebook, American Association for Long-Term Care Insurance.

All of these “innovations” are far more likely to benefit the insurance industry than consumers. Policymakers and regulators need to pay greater attention to the group market and to the innovation occurring in long-term care insurance products to ensure that benefits will not become illusory over time, and will cover insignificant amounts of the cost of care. If the goal is to have more people buy commercial products to pay for long-term care and relieve pressure on state Medicaid programs, then benefits have to be in place when care is needed and must cover a substantial amount of the cost. Many of the products being sold today may not meet that criteria, and could leave consumers with huge out-of-pocket costs when care is needed 20, 30, or even 40 years later.

VI. Partnership Programs

A Partnership program, in theory, allows consumers to shelter certain amounts of their personal assets from the state Medicaid program by buying a long-term care insurance policy that meets federal rules and pays benefits for their future care. In return, the state promises that if the individual later qualifies for Medicaid benefits, each dollar of insurance benefits paid out will protect one dollar of their assets from the state’s spend down requirements, and later estate recovery actions.

Careful consideration must be given to the state’s role in the promotion, marketing, and sale of a commercial product that may be in conflict with their role as a government agency and thereby draw public criticism.³⁶ Such a relationship with the private market requires careful monitoring of the products and the people who sell them to maintain the program’s integrity and ensure continuing consumer confidence in the program.

Commercial insurance companies and their sales agents clearly have a compelling and valuable marketing advantage when a state Medicaid program enters into a long-term care insurance Partnership program. This is because an insurance policy that is endorsed by the state makes it instantly both more attractive and credible. While sales opportunities for these products begin immediately the effect, if any, on a state’s Medicaid program will not be known for many years.

To ensure that companies and sales agents don’t exploit their connection to state government, states must develop strong standards for marketing and sales conduct, and comprehensive and ongoing training requirements. Consumers must be protected from overzealous advertising and misleading sales promotions, particularly older purchasers who may be a prime market for agents selling a state-approved product, and one that the state may even promote and encourage its residents to buy. Insurers often offer bonuses, incentives, and other sales reward programs to agents to increase sales of long-term care insurance, and those financial rewards may compete with a state’s interest in the appropriate marketing and sales of these state-endorsed products.

³⁶ See e.g.: “States Draw Fire for Pitching Citizens On Private Long-Term Care Insurance,” Wall Street Journal, Jennifer Levitz and Kelly Greene, 2/26/08. <http://www.consumerwatchdog.org/patients/articles/?storyId=18819>.

Taking advantage of the halo of state endorsement, sales agents may also include other insurance products in the same sales session, such as life insurance, annuities, burial insurance, and even reverse mortgages as a method of financing the premiums of a long-term care insurance policy. States should fully consider the effect of cross selling other insurance products to prospective purchasers of Partnership policies.

State Medicaid programs may benefit if a person uses their insurance benefits instead of Medicaid, or delays accessing Medicaid until their insurance benefits are exhausted. However, a 2007 study by the GAO found that it could be just as likely that these Partnership arrangements may actually increase Medicaid costs if people qualify for Medicaid benefits sooner than they would have with a traditional long-term care policy, or with self-financing.³⁷ The asset protection provided by the Partnership shields money that people would otherwise have to spend down before being eligible for Medicaid coverage. As a result, people may be able to qualify for Medicaid sooner than they would without a Partnership policy.

Advocacy groups are justifiably concerned that some people with moderate incomes will spend a large percentage of their income to protect small amounts of assets that may already be exempt under federal spousal impoverishment law for purposes of Medicaid eligibility. Another concern is that these policies will be inappropriately sold to people who have neither the income to pay for them over time, nor significant assets to protect. Other concerns focus on whether the promised asset protection can ever be used since at least some number of people who buy these policies will never qualify for Medicaid because their incomes are too high. Other issues include concerns that policyholders may have insufficient daily benefits, or may have failed to buy enough asset protection, and their assets will be consumed by out-of-pocket costs that are greater than the benefits they are collecting.

Because asset protection is only accumulated as benefits are paid some people of modest means may have to spend down some of their assets at the same time benefits are being paid if their out-of-pocket costs are greater than can be absorbed by their income. In other cases one spouse might be prevented from seeking spousal impoverishment protection³⁸ while the other spouse is in a nursing home and waiting for policy benefits to be exhausted and asset protection to apply to their non-exempt assets. Younger purchasers who buy a policy that qualifies for Partnership status with the required inflation protection could lose the Partnership status if their right to a future purchase option expires and the policy no longer meets federal requirements for inflation protection.

For many of the reasons stated above, the promises being made about Medicaid and Partnership policies may not be met in the future. While the 4 original Partnership states³⁹ require a minimum daily benefit and a built-in method of inflation protection, most of the newer Partnership states do not, and rely instead on policies that meet their own state requirements and have inflation protection that complies with federal law.

³⁷ "Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings" GAO May 2007 <http://www.gao.gov/new.items/d07231.pdf>.

³⁸ Section 1924 of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396r-5.

³⁹ Connecticut, New York, Indiana, and California.

Consumers may be buying benefits in the newer Partnership states that will be insufficient to pay a substantial portion of their long-term care later, either because the daily benefit amount is too low, and/or because the method of inflation protection they chose is insufficient to keep up with the cost of care. The out-of-pocket expenses that result may exceed an individual's current income, thus causing a person to spend down assets that are not yet protected.

In other cases people may not understand that even though they have the promise of asset protection, or may even have accumulated a specific amount of asset protection, their income, and/or non-exempt assets, could prevent them from qualifying for a state's Medicaid benefits. The 2007 GAO report found that 55 percent of Partnership purchasers over age 55 had monthly incomes of \$5,000 or more that would disqualify them for Medicaid, and 53 percent had assets of more than \$350,000.⁴⁰ Even with a policy that paid \$200 a day, it would take almost 5 years of benefit payments to provide asset protection equal to \$350,000 when the average nursing home stay is less than 3 years.

The relationship between commercial insurance products and a public benefits program through a Partnership agreement is a complicated arrangement, with many opportunities for confusion. Written descriptions and explanations of a Partnership program, and the interaction between a commercial insurance policy and a state's Medicaid program should be drafted by the state Medicaid office with verbatim use required by agents and companies. Consumers need an official explanation of Medicaid eligibility requirements, Medicaid benefits, asset protection accumulation and application, and estate recovery actions in their own state. They also need information about how the Partnership protection might work in other states, if at all, in the event that they use their policy in a state different than the state of purchase. The opportunity for confusion is significant for people living near state borders where differences between Medicaid programs in the bordering states can add even more confusion and complexity.

Additionally, consumers need to be aware that states can change their Medicaid program at any time, and that they will have to meet the eligibility requirements in place at the time they apply for benefits in the state of purchase, or the state they move to later. Consumers also need to understand that: 1) asset protection reciprocity is not assured; 2) Medicaid benefits available in their own state may not be covered in another state; 3) another state may apply a different standard to achieve complete asset protection than the state in which they bought their policy; and 4) states can withdraw from active participation in a Partnership at any time.⁴¹

Much of the success of long-term care insurance, in or out of a Partnership program, depends on the quality and dependability of the products that are purchased, adequate regulatory oversight, and whether people buy and keep these policies far into the future and are able to collect later on the promises they purchased.

⁴⁰ Long-term care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings, GAO May 2007 <http://www.gao.gov/new.items/d07231.pdf>

⁴¹ Reciprocity standards issued by the Department of Health and Human Services allows states with Partnership programs to apply their own Medicaid rules to a Partnership policy purchased in another state. States may opt out of reciprocity, or participation in a Partnership program, at any time. See Reciprocity Standards Draft 2 at <http://www.dehpg.net/LTCPPartnership/generic.aspx?idir=federal%20guidance%20documents>.

VII. Regulatory Oversight

During the last decade insurance companies and industry groups have argued for the option of a federal charter to regulate the business of insurance, which would essentially allow companies to select their own regulator by choosing between state or federal regulation. A New York Times May 21, 2009 editorial opined that if legislation introduced in the House to create an option federal charter⁴² were to pass that “the race to the regulatory depths would continue, and the nation would be headed in exactly the wrong regulatory direction.”⁴³ Such a choice would allow companies to escape the more rigorous regulatory requirements of many states like California that impose strict standards on companies and the long-term care products they sell. For instance, more stringent requirements for initial rate approval in California and the requirements that apply to rate increases could both be avoided by companies seeking another venue of regulation, and the careful scrutiny that some states provide to each policy filing might also be avoided.

Federal law does though, provide important protection by establishing minimum federal standards for long-term care insurance products, as it did in the Health Insurance Portability and Accountability Act (HIPAA)⁴⁴ and in the Deficit Reduction Act (DRA).⁴⁵ In an effort to further improve consumer protection, however, federal law could mandate additional minimum standards by directing the NAIC to gather data from the states, form a working group to identify the strongest standards and consumer protections enacted in states, amend those standards and protections into the NAIC Models, and then incorporate the NAIC Model into federal law by reference. This process was used when standardizing Medigap policies under OBRA '90, where federal law mandated the participation of federal agencies, consumer groups, industry representatives, and regulators to work together to accomplish that task.⁴⁶

Greater state oversight is needed of long-term care insurance products, and riders that are attached to other insurance products like life insurance and annuities, and the agents who sell these products. Long-term care insurance products contain an assortment of benefits and features, and come in policy designs that vary from one company to another, leading to significant product differences within a single state despite what appear to be similarities of benefits. In addition, an assortment of riders can be added to policies that enhance, change, or modify the benefits of a base policy.

Few elements of a long-term care insurance policy or rider are standardized leaving consumers unable to compare several different policies. Benefits may appear to be the same, but the details of those benefits make it impossible to do a side-by-side comparison among several products or know how the benefits will work when needed. Many consumers simply rely on choosing the policy with the lowest premiums even though it may have fewer benefits, expensive gaps in benefits, higher out-of-pocket costs than expected,

⁴² H.R. 3200, Rep. Melissa Bean (D-IL) and Rep. Ed Royce (R-CA).

⁴³ New York Time Editorial, “Regulator Shopping,” May 21, 2009.

⁴⁴ The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191).

⁴⁵ The Deficit Reduction Act (DRA) of 2005 (P. L.109-171).

⁴⁶ Omnibus Budget and Reconciliation Act (OBRA) of 1990, Pub. L. 101-508.

and the potential for a steep increase in premiums later.⁴⁷ It is even more complicated for consumers when a policy is paid with a single, large premium, or when long-term care benefits are combined with a life insurance product or an annuity.

The NAIC and state regulators can play an important role in bringing some standardization to this market, eliminate some of the current confusion, and make it easier for consumers to make a choice between different products. Even when consumers have a fair idea of the benefits they bought, those benefits often don't keep up with changes that occur in long-term care services over time. In addition, since these products are usually purchased years or decades before care is needed, the individual arranging care for the policyholder will have to figure out how the policy works, what is covered, and how to comply with the various requirements for filing a claim. When a claim is filed policyholders are at the mercy of a company's interpretation of their benefits.

For example:

General Electric Capital Assurance Company (now Genworth) denied assisted living benefits described in a policy issued in New York, because at the time of the claim, the state of New York did not license assisted living arrangements.⁴⁸

In a more recent example Mrs. KC, who bought her AMEX (now Genworth) long-term care policy in California in 1992, was denied her assisted living benefits because the state licensed assisted living home her family chose has only 6 beds and not the 10 beds required in her policy. Her family chose that particular assisted living home because of its individualized dementia services but now must move her back to a larger facility, losing the individualized services they valued so highly, and which have made a marked difference in Mrs. KC's day-to-day life. Since purchasing her policy Mrs. KC has paid approximately \$50,000 in premiums for benefits she is now unable to collect because of a difference of 4 beds.

Mrs. K. bought a Pioneer Insurance Company (now Conseco) long-term care insurance policy in 1990 that only pays for care at home and has no other benefits.⁴⁹ She did, however, have the foresight to purchase an 8 percent compounded inflation protection benefit, a very rare benefit to be offered or purchased in 1990 which illustrates the seriousness with which she attempted to plan for her future care. Despite Mrs. K's prudent planning her claim for benefits was denied. Now 86 years old, Mrs. K has dementia and is living in a state-licensed assisted living home in California that is also licensed to provide specialized services to residents with dementia.

⁴⁷ See: Burns, Bonnie, Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers, May 2006, http://www.aarp.org/research/longtermcare/insurance/2006_13_ltc.html.

⁴⁸ See *Van Houten v. General Electric Capital Assurance Company (GE)*.

⁴⁹ Conseco recently settled a multi-state market conduct examination related to long-term care claims practices and procedures, complaint handling, and sales and marketing practices in which almost 40 states participated, led by Pennsylvania, Illinois, Indiana, Texas and Florida. See also California Department of Insurance Order to Show Cause and Notice of Hearing File No. 05048841 in regard to long-term care insurance claims, for engaging in unfair acts or practices of the Fair Claims Settlement Practices, and unfair acts and deceptive practices of the California Insurance Code.

Mrs. K is getting the same personal care services she could receive if she were living in her single family home, but in this home she has round the clock supervision, specialized activities for people with dementia, and socialization with other people who have the same condition. This assisted living home is not licensed to provide skilled nursing care nor is it a skilled nursing facility.

Yet the company refuses to pay her home care benefits arguing that this assisted living home meets the definition in the policy of a licensed skilled nursing facility and is therefore excluded as a place of care, and that the personal care services described in the policy which Mrs. K is getting are not being provided by a licensed home health agency as required by the policy but instead are provided by the staff of the assisted living home. Nowhere in the policy is a person's home defined, nor is there a definition of where policy benefits will be paid.

These cases illustrate how companies rely on the fine print in a policy, and what is not in the fine print, and is often at odds with the advertising material a consumer sees that implies coverage is more generous than it is. State insurance departments may not have the authority to force a company to pay benefits when there is a dispute involving interpretations of policy language, but issues like these could be minimized with greater standardization and more oversight and review of how these products are marketed and sold.

Rules could be developed to prevent companies from using language in advertising that is subtly different than the language of the contract, and policy review and approval by people experienced in long-term care would allow them to catch and correct policy language that conflicts with long-term care services and the delivery system for care.

CONCLUSION

The success of long-term care insurance products depends on the quality and dependability of the products, regulatory oversight, whether people buy and keep these policies until they are needed, and whether they are able to collect benefits later based on the promises they purchased. If the goal is to have more people buy commercial products to pay for long-term care and relieve pressure on state Medicaid programs, benefits have to be in place when care is needed and must cover a substantial amount of the cost.

Minimum national standards allow states to enhance those standards and develop other standards for issues not yet addressed by the NAIC Models and help ensure that the quality of a long-term care policy is not completely dependent on the state in which the policy is purchased. However, the NAIC process does not lend itself to finding and including in the Models the best standards that have been developed by the states. Nor is a scheduled periodic review performed to find changes that may have occurred in long-term care services or the long-term care delivery system. Having a regular process to find the best standards among the states and to track changes in LTC services and the care system are important components to strengthening consumer protections and quality of LTC insurance products.

As part of health care reform, elders and people with disabilities who need long-term care should have a seamless transition to long-term care services, coordination with medical care, and a support system to help them find and access the services best suited to their needs.

With the expansion of the Partnership program in approximately 20 states, closer coordination and monitoring is required between the state Medicaid agency and the insurance department in each state, to ensure that marketing and sales materials accurately portray the interaction between a commercial insurance product and the state's Medicaid program. States must be vigilant to ensure that consumers are not being promised state benefits they may not get, and that consumers fully understand both the commercial and public promises they buy. Sales and marketing materials must accurately reflect a state's Medicaid program, and sales agents must be carefully trained to understand the limitations and restrictions of Medicaid eligibility, and accurately communicate that information in to consumers.

We thank you for the opportunity to testify today on these important issues and welcome any questions you may have.

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ATTACHMENT A

Conseco Senior Health Insurance Company's Transformation to a Non-Profit Company

Background

In 1996 Conseco acquired American Travelers Life and Transport Life and the long-term care business of the 2 companies. Conseco previously acquired Pioneer Life and a number of blocks of long-term care insurance from other companies in an effort to become a major player in the long-term care business during the 1990s. In 1998 Conseco merged most of their long-term care business into a new subsidiary company named Conseco Senior Health Insurance Company (CSHIC). Conseco also owns Bankers Life and Casualty Company that has substantial long-term care business and remains a subsidiary company.

CSHIC stopped selling long-term care insurance in 2003 after incurring substantial losses. The magnitude of those losses, and the capital contributions made by Conseco to CSHIC to mitigate some of those losses, caused significant stress on Conseco's financial resources. As a result, Conseco approached the Pennsylvania insurance department with a proposal to spin off CSHIC into a trust arrangement.

In November 2008 the Pennsylvania insurance department allowed Conseco, Inc. to implement this unique arrangement and separate its failing subsidiary company CSHIC from Conseco's holding company system into a trust that has been renamed Senior Health Insurance Company of Pennsylvania (SHIP). This new arrangement eliminated the potential of any further losses to Conseco's holding company system.

The new company holds all the assets, liabilities, and surplus of CSHIC, for the sole benefit of the policyholders. Closed blocks of long-term care business from other Conseco subsidiary companies were transferred to the new company for administration, bringing the total number of covered lives in the new company to 177,000.

Financial Condition

Between 1998 and 2008, Conseco made 10 capital contributions to CSHIC totaling \$915.1 million. As a condition of the separation of CSHIC into the trust, Conseco agreed to make a final contribution of \$50 million in cash or cash equivalents, and another \$125 million in the form of a senior note, a combined amount far less than the capital contributions made by Conseco over the last 10 years.

The new company SHIP, has no further access to any assets or capital of the holding company system. It must rely solely on current capital and reserves of CSHIC, and the revenues that can be generated from premiums paid by policyholders transferred to the trust, except for those policyholders who have triggered a survivor's benefit and no longer pay premiums. In 2008 the company expected to pay out \$1.35 in claims for every dollar of premium collected, as reported in documents filed with the Pennsylvania insurance department.

A 2008 actuarial report by Milliman, Inc., an actuarial consulting firm referenced in the Separation and Transition Agreement, included solvency projections that assumed 5 additional rate increases would be needed for the policies transferred to the new company as of 2009.¹ Premium increase notices for CSHIC products have already been received across the country within the last few months, most in the range of 40 percent. For some consumers with a policy issued by Conseco, this rate increase follows previous rate increases of 18% in 2002, 20% in 2004, and 15% in 2008. The latest rate increase is apparently the first of the 5 additional rate increases projected in the Milliman report.

Consumer Protections

As a result of the recent round of rate increases by Conseco Senior Health Insurance Company on behalf of the non-profit Senior Health Insurance Company of Pennsylvania, policyholders may have one or more of the options listed below, depending on the state they live in.

- In states that have adopted Section 28 of the NAIC Model Regulation pertaining to Contingent Benefit on Lapse (CBoL), consumers might trigger the option to lapse their policy and retain paid-up benefits equal to 100 percent of the premiums they have paid, depending on a state's implementation of that requirement.
- Policyholders with policy form numbers that were included in a national class action lawsuit may have the option to exercise a non-forfeiture benefit equal to some percentage of the premiums they have paid.
- In states that have adopted Section 27 of the NAIC Model Regulation pertaining to the right to reduce coverage and lower premiums, policyholders may have the right to reduce their coverage by shortening the duration of coverage, lowering the daily benefit amount, dropping inflation protection, or increasing the waiting period before benefits are paid. Each of these choices, alone or in combination significantly affects future benefits.
- Rate increase notices may include offers of specific reductions that can be made in a policy's benefits in return for a reduction in the premium increase.

In some states a policyholder may be offered more than one of these options at the same time. Notice of a rate increase may include a list of options that are available to a policyholder that will reduce the amount of the scheduled premium increase.

¹ See Exhibit O at <http://www.ins.state.pa.us/ins/lib/ins/conseco/018.pdf>

Most consumers will need assistance deciding which of the options offered to them is best suited to their needs. It will be particularly difficult for policyholders with unlimited benefits to choose one of the options offered to them in lieu of those lifetime benefits. These notices should have, but were not required to, include information about the availability of assistance from the federally funded State Health Insurance Assistance Program (SHIP) that is available to consumers in every state.

The Future of Senior Health Insurance Company of Pennsylvania

A significant, but unknown number of current policyholders have exercised a survivor option that was widely sold to couples, and owe no further premium payments for the benefits they purchased after one of the spouses died. Some number of current policyholders will be eligible for this feature upon the death of their insured spouse. Some policyholders who have the option to lapse their policy and retain paid-up benefits instead of paying the increased premium are likely to do so. In each of these situations there will be no more premium revenue available from those policyholders, and no access to capital contributions from any other source. Any remaining rate increases will have to take into account these and other factors, including shock lapses⁵⁰ that occur as a result of this current rate increase, and any additional increases.

Professor Joe Belth, University of Indiana, submitted comments to the Pennsylvania insurance commissioner, Joel Ario prior to the transfer of Consecro Senior Health to the trust, stating, "The Department should disapprove the Plan, Consecro should *not* provide the additional capital contribution of \$175 million, and the Department should seize CSHI as soon as possible. The Plan postpones the inevitable. A prompt seizure of CSHI would provide the Department with a better chance of selling or rehabilitating CSHI, and therefore a better chance of avoiding the drastic alternative of liquidation, than a postponed seizure."²

In the June issue of his newsletter, The Insurance Forum, Professor Belth calls into question the ability of Consecro to meet their obligation under the senior note owed to SHIP, based on their delayed 10-K filing with the Securities and Exchange Commission, and an opinion by its independent auditors. Professor Belth also calls into question a permitted accounting practice approved by the Pennsylvania insurance department that allowed SHIP to account for the Consecro senior note as though it had been fully paid in cash, leading to a higher score for their statutory risk-based capital requirements than they would have had otherwise.

In addition to the normal business related expenses of an insurance company, the new company SHIP must still meet all the capital requirements of an insurance company to remain in business. In the current financial climate that may be difficult to do.

⁵⁰ A shock lapse is one that occurs when the size of the rate increase is too large for a policyholder to absorb and they simply stop paying premiums and allow the policy to lapse.

² See: Opinion of Professor Joe Belth at <http://www.ins.state.pa.us/ins/lib/ins/consecro/034.pdf>



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ATTACHMENT B

Seizure of Penn Treaty Network America Insurance Company By the Pennsylvania Insurance Commissioner

Background

Penn Treaty Network America Insurance Company (PTNA) and American Network Insurance Company (ANIC) are both subsidiaries of Penn Treaty American Corporation (PTAC), a holding company domiciled in Pennsylvania. PTAC through its subsidiary companies has been writing long-term care insurance since 1972, and by the year 2000 had 250,000 covered lives. By 2008 that number had dropped to 142,000.

Products sold by both companies were offered through a network of 17,000 agents with substantially lower premiums than other policies on the market at the time. Rosanne Placey, a spokesperson for the Pennsylvania Insurance Commissioner, recently explained that policies written prior to 2000 had been under priced, and the company had had difficulty getting approval for the rate increases in the amounts they had requested from the various states in which it had sold policies.¹

Financial Condition

The company is currently under a voluntary rehabilitation order in the state of Pennsylvania due to the historical and current inadequacy of its rates on policies sold prior to 2002. The ability to emerge from rehabilitation is dependent on the company's ability to substantially increase rates across the country, and to cut its operational costs.

The inadequacy of its rates was identified in 2001 following a series of rate increase requests that some states approved, some resisted, and some approved less than requested. Between 2000 and 2008 the company shed more than 100,000 covered lives through death or lapse.² Some of the lapses were undoubtedly in response to previous rate increases that could not be absorbed by elderly policyholders.

¹ See: Long-Term Care Insurer Penn Treaty American Fails 01/08/09 - 05:26 PM EST
<http://www.thestreet.com/story/10456908/long-term-care-insurer-penn-treaty-american-fails.html>

² Pennsylvania Rehabilitation Order
http://www.ins.state.pa.us/ins/lib/ins/liq_rehab/penn_treaty_network_america_ins_company_rehabilitation_order_jan_6_2009.pdf

The size of the rate increases that may now be required to restore Penn Treaty Network America to financial health may be too large for some state insurance departments to swallow. However, state guarantee funds with statutory limits on coverage would effectively reduce some policyholder's benefits, in particular those with unlimited or life time benefits. State regulators will be in a difficult position faced with a choice between approving large rate increases that will keep Penn Treaty Network America in business, or allowing the company to become insolvent with the result that at least some consumers will lose some of their benefits in the state guarantee funds.

Consumer Protections

As a result of the recent round of rate increases by Penn Treaty Network America Insurance Company, policyholders may have one or more of the options listed below, depending on the state they live in.

- In states that have adopted Section 28 of the NAIC Model Regulation pertaining to Contingent Benefit on Lapse (CBoL), consumers may trigger the option to lapse their policy and retain paid up benefits equal to 100 percent of the premiums they have paid depending on how this feature was implemented in a state.
- Policyholders with policy form numbers that were included in a national class action lawsuit may have the option to exercise a retention benefit equal to 50 percent of the premiums they have paid.
- Policyholders with policy form numbers subject to other class action remedies may have retention benefits equal to 100 percent of the premiums they paid.
- In states that have adopted Section 27 of the NAIC Model Regulation pertaining to the right to reduce coverage and lower premiums, policyholders may have the right to reduce their coverage by shortening the duration of coverage, lowering the daily benefit amount, or increasing the waiting period before benefits are paid. Each of these choices, alone or in combination significantly affects future benefits.

In some states a policyholder may be offered more than one of these options at the same time. Notices of the rate increase typically include a list of the options available to a policyholder that will reduce the amount of the scheduled increase. If the option of a retention benefit, or paid up benefit on lapse applies, the amount of premium that will be set aside to pay future benefits is typically included in the notice.

Most consumers will need assistance deciding which of the options offered to them is best suited to their needs. It will be particularly difficult for policyholders with unlimited benefits to choose one of the options offered to them in lieu of those lifetime benefits. These notices should have, but were not required to, include information about the availability of assistance from the federally funded State Health Insurance Assistance Program (SHIP) that is available to consumers in every state.

The CHAIRMAN. Thank you very much, Ms. Burns.

Dr. Rowland, what guarantee do consumers have that a long-term care insurance policy purchased today will indeed deliver the benefits for them 20 or 30 years from now?

Dr. ROWLAND. Well, I think you hit on, perhaps, the most serious question in someone's decision to buy a long-term care policy—and the ability to deliver on those benefits. The guarantees of what our healthcare system—what our long-term care system are going to look like in 20 or 30 years—are not there. We don't know what kind of technologies will be available, and what kind of other options individuals may want to use, for their long-term care benefits.

So, I think one of the challenges, here, is really this time lag between when you decide to purchase a long-term care policy, and when you might use it. I think the guarantees are extremely limited, and that's where consumer protection is going to be very important.

The CHAIRMAN. So, I hear you saying that there really are no concrete guarantees that—

Dr. ROWLAND. Well, no guarantees that the policies purchased today will meet your needs when you need them, 20 to 30 years down the road.

Especially, there are problems if individuals can't continue to pay their premiums. They may pay premiums for 10 or 12 years, and then have income limits and other problems that prevent them from continuing, so that by the time they need long-term care services, that policy may no longer be guaranteeing them anything.

The CHAIRMAN. Do—anybody on the panel disagree with that? I mean, it's a pretty basic question and we hear Dr. Rowland with a very skeptical kind of an answer. What about you, Mr. Dilweg?

Mr. DILWEG. I think it raises the major point, as Dr. Rowland said. The issue, though, is, are there abilities to look at new benefits throughout the life of the policy? The problem that we're having with some of the older policies is that they primarily were just locked into nursing home care, and as we know, that has changed significantly. So, are those options there? How do the various cost factors factor in?

But, I do think it shows, really, the shortcoming of the product; we continually emphasize that you should not make this decision in a vacuum. You might be better off, not necessarily in the past four months, with a mutual fund, with money in savings, or some other investment vehicles that may treat you better in the future. So, do not make this decision in a vacuum, and we continually emphasize that.

The CHAIRMAN. Mr. Stinson?

Mr. STINSON. Yeah, just a couple of other points I'd like to add to the commentary.

One is, obviously, I have a contractual obligation to the policyholder to fulfill all of the benefits that are in that contract. As Mr. Dilweg pointed out, the policies that we sell today provide significantly more flexibility in terms of how the benefits can be paid and where they can be paid. Policies I sold from the mid-seventies to the mid-eighties were nursing home-only policies. As the care environment has evolved, that's where you've got some of the friction from the older policy owners. But the policies I sell today have tre-

mendous flexibility in terms of how those benefits can be applied to the consumer.

One of the other things that I'd like to point out is the fact that our persistency on this product is incredibly high, meaning the number of policyholders that retain the policy and don't voluntarily lapse it, compared to life insurance or annuity contracts is about 1 percent, so the persistency is 99 percent of the people on the annual basis retain this coverage and pay it until, either they die, or they need benefits.

The CHAIRMAN. So you—to be pretty stark about it, or to be pretty optimistic about it—you don't entirely agree with Dr. Rowland?

Mr. STINSON. I do not, with regard to the policies that we're selling today. Again, I have a contractual obligation to the policyholders. I think the training that's provided today to our agents that are selling the contracts, is well explained. We have NAIC obligations to provide disclosures on what the policies do and don't cover, and in terms of my responsibilities, again, tremendous flexibility within the contracts to allow the consumer—as the care environment develops over the next 20, 30 years, to be able to use that policy within that context.

The CHAIRMAN. So you regard the long-term care insurance policies that you're selling today as a reasonable, pretty good buy for the people who are buying them?

Mr. STINSON. I do.

The CHAIRMAN. Well, what about it, folks? The man looks like a man of integrity.

Ms. BURNS. Senator Kohl, if I might?

Mr. STINSON. My mother owns a policy.

The CHAIRMAN. All right, Ms. Burns, do you want to make a comment?

Ms. BURNS. I did. Part of the problem with this product is the difficulty with definitions, and in looking forward and trying to figure out how a policy would adapt to future changes, is one of those issues.

For instance, some companies sell something called an Alternate Plan of Care, which is totally undefined in a policy and yet leaves the impression with consumers that they'll be able to bargain with the company for various benefits, later that are not covered in the policy.

We've had a number, of cases in our state involving that particular benefit, and the inability to use it. It's completely within the discretion of the company to decide what that benefit is, and whether or not they're going to allow it to be used.

I think standardized definitions of many of the features of a policy might go a long way to helping consumers get the benefits that they need. But it is a difficult prospect to think about how to make one of these policies adapt to future needs and future technology.

The CHAIRMAN. Is that a fair statement, Mr. Stinson?

Mr. STINSON. Yeah, I would add that—the flexibility that was provided in this alternative plan of care—if the policyholder presents their claim in any one of the defined terms within the contract, I'm obligated to pay that claim.

We added these alternative plans of care, because the evolving care environment. There was no such thing as a, you know, resi-

dential care facility 20, 30 years ago. That's some of the problems that we ran into.

So, I have specific definitions of where I must apply the benefits of the policy. Nursing home definition, assisted living facilities, and the care that I can provide in the home.

As I look forward 20 to 30 years from now, those things that I can think of in defining the contract, I can't necessarily predict everything, so the insurance companies have provided this flexibility of an "alternative plan of care" that says, if something is on the horizon that I can't define today, we want the insured to have the ability to get access to the benefits of the policy.

Ms. BURNS. I wouldn't disagree with that, but I do think that this is company specific. There are some companies who are better at doing what they do than other companies. I think part of this is a problem between the various ways that companies look at this product and these benefits. In addition state regulators have some effect on this issue.

The industry is not homogeneous. They don't, all of them, do the same thing in the same way. Some companies are better than others, some companies are worse than others.

The CHAIRMAN. OK.

Mr. Dilweg.

Mr. DILWEG. I think it raises another point where this really, has become more of an individual product. It's a very complicated product, and the key is making sure the agents are educated. I think standardizing language also helps the individual navigate between the various companies and would be a good step.

So, just the delivery of the product as it runs through the agents where you have the individual trying to make the decision on their own and may want to look outside of the agent. It's important to recognize how it is delivered.

The CHAIRMAN. Ms. Cutter.

Ms. CUTTER. Thank you, Senator. A couple of comments. There are things in these contracts, and to Mr. Stinson's point, an insurance policy is a legal contract. That company is bound by law to provide the benefits that are stipulated within that contract. What happens if—to Commissioner Dilweg's point earlier, when he talked about financial solvency—it's each State's responsibility to monitor, very closely, and scrutinize financial solvency of each of the domestic companies that are within their borders.

We have had a couple of situations—not in Indiana, although the holding company was in Indiana, but the actual base company was in Pennsylvania—that sold a lot of long-term care coverage and didn't price it well.

One of the things that Bonnie referred to earlier that I, as an agent, absolutely object to is a particular company that's been so problematic and sold what are called "five-year rate guarantee" policies. They went in and told consumers, "Your rates aren't going to change for five years," and they didn't. They held to that promise.

The problem is, I've spoken to thousands of people over the years and I can tell you, if you say "guarantee" to an individual, that's all that stays in their head. They aren't going to remember that five years from now that's going to change. So, when the change

occurs, they believe they've been wronged or harmed, because they believed that it was guaranteed forever.

There is no insurance product in the marketplace—no car insurance, no homeowners' insurance, no term life insurance, no health insurance—that can say to you it's not ever going to go up. They can't say that. So, consequently, long-term care is no different in that regard, and that's why I think the ability for States to really scrutinize these rate increases, or the initial rates, that are submitted by companies is just a critical, critical step in terms of trying to force them to be more responsible in their initial submission of rates, in terms of them being adequate.

One of the things that our actuary says to me all the time is, "A long-term care policy is what is known as an indemnity policy, which means as an insurance company, I'm going to pay you this when this happens." So, if you go into a facility, or you need care—and my husband and I are covered under a long-term care policy that I bought 10 years ago, it's \$200 a month, it's not expensive, and it covers us for three years, and it's got an inflation-protection rider on it, and we started out at \$150 a day. Well, right now, in Indiana, the average nursing home cost is \$110 dollars a day. So, I'm already ahead of the game, thank goodness, because of the way these products are designed.

But the point being that, as I go forward into the future, with the inflation protection in that product, I know that I'm going to be able to keep up with—and I hate to admit it, but it's not a Partnership product, so I don't have asset protection—but I know that I have the ability, at least, for two or three years—because it is a three-year payout—to protect us and be independent in our decisions about what kind of care we're going to receive, and where we're going to receive it. I think that's critical as a part of the insurance world, in terms of how consumers can help make these decisions for themselves, and not always look to you folks to be handing out dollars for them, because they haven't maybe been quite as responsible for themselves as they should have been.

The CHAIRMAN. Well, that brings up the next question to the panel, do you believe that long-term care is fundamentally an insurable kind of a product, an activity, or do you believe it is more appropriate to cover these services through a societal program, like Social Security or Medicare?

Mr. Stinson.

Mr. STINSON. I believe it is an insurable event that insurance companies can predict. Our actuaries are basically looking at two variables, here, instead of just mortality on life insurance contracts—they are tracking mortality and morbidity. We believe that the morbidity patterns are insurable. We can pool the risk, and have an efficient insurance model that ultimately, everyone is paying premiums in.

Again, about half the people that buy our products ultimately will use the products, but we believe it is an insurable event and there are actuarial models that can predict the morbidity trends, as well as the mortality trends.

The CHAIRMAN. Yes, Dr. Rowland?

Dr. ROWLAND. Well, I certainly believe that there is a role for private insurance, and for trying to provide that for individuals.

But, I think—and maybe I studied the health insurance side of our health care system too long—that there are always going to be individuals for whom this kind of an option is not affordable, and not available.

So, I think that the partnership that now exists between Medicaid and private insurance is probably more appropriately a partnership that could exist between Medicare and private insurance where, at least, some basic benefits were provided. Individuals would have that protection through the social insurance mode, and then could supplement that, or add to it with private insurance. That may be a more appropriate model for how to go.

The CHAIRMAN. Mr. Dilweg.

Mr. DILWEG. I would agree that there's definitely an insurable interest, an insurable event that you can define, triggers that can be defined. In the end, I think, by having some sort of partnership, you have a more efficient use of money, and a spreading of the risk, by treating part of long-term care as insurable.

The CHAIRMAN. Ms. Burns.

Ms. BURNS. I agree that there's a role for long-term care insurance. I'm not sure we know how big that role is yet. There are a number of issues involved around this topic. One is, the benefits people buy when they first buy coverage, and whether or not they're trading off the cost for benefits that are not going to be sufficient later.

This is particularly crucial in the group market, for working-aged people who buy a future purchase that allows them to buy option inflation later, at an increased cost. As time goes on, that cost becomes greater and greater, and they may then not take exercise that option, and then eventually lose it.

So, it's an issue of, not just about what people purchase, initially but whether it's suitable for them, or not, and whether it will do what they expect it to do, years or decades later. It's everything that happens between purchase and use.

As I said before, companies are not homogeneous, they do different things, and they do them in different ways. So, someone may buy a product that was a perfectly affordable for them when they were 60 years old, and when they are 75, it may not be. They may, then, be forced to drop it.

So, there are a number of things that happen along the way, making it a complex topic. I think that there are a lot of these pieces we don't quite know, yet, and that there's still a lot of work to be done.

But helping people compare these products—apples to apples, and not apples to peaches—would certainly help by standardizing some of the language within the policy, so that people have a better grasp of what they're buying, and they're not buying just based on price.

We buy based on price for almost everything else we purchase. So, it's not unreasonable to think that people would do that with long-term care insurance. Buying the lowest priced policy—at least in the recent past—has been buying a rate increase later that some people couldn't afford to pay.

The CHAIRMAN. All right, which leads us, maybe, to the next question.

Mr. Dilweg, how did policies sold during the eighties and nineties differ from policies sold today? Why did they price their policies so low at that time? Do you see any danger in underpricing today in the group market?

Mr. DILWEG. I think Mr. Stinson addressed this, as well, I think we both spoke to it. There really were problems, in a sense, insurers were trying to buy up the market and under pricing the product. Some were locked into just nursing home care, you did not have a lot of the changes that have been made at the NAIC as far as how products should look—the flexibility, the attempt to try and get stability.

I do think it's important that a lot of changes we've made since 2000 be reflected in the Partnership plans through Health and Human services. Really, what your bill is attempting to do, I think, is a very good step to making sure that that flows through both Medicaid and the tax-qualified entities, as well.

So, I think there's been a lot of progress, and I think you're going to see just as much progress 10 years from now, in the regulation of these products.

The CHAIRMAN. Mr. Dilweg, what are some of the high-priced sales tactics that occur in selling long-term care insurance?

Mr. DILWEG. I think what we saw—and, it almost reminds me of our conversations on Medicare Advantage, Senator—as you introduce a new product, you have the agents—and this goes back a ways—but you have the agent really wanting the person to sign on the dotted line before they leave the house, not properly identifying what a guarantee is, things like that which may come back to haunt the individual.

I think we've tried to spend a lot of time on agent education. These are very complicated products, and we need to continue to do that. But one suggestion here today, really, a standardization of definitions, I think, would be very helpful. Then someone can compare Genworth to Prudential, to whomever else.

When you think about long-term care, you think about healthcare, but it's not typically healthcare companies who sell these. It's typically life insurance companies that sell these. So, it's really a—when you think of the companies that sell these, it's a unique product in how it's lodged in the corporate structure, as well.

Mr. STINSON. Just a couple of remarks on the—

The CHAIRMAN. Mr. Stinson.

Mr. STINSON [continuing]. On the—you'd asked the question on the rates of yesteryear and what the insurance companies are doing today.

Two perspectives, one is, when the companies were filing the products, say, 15, 20 years ago, there was generally, I think, at the State level, the sensitivity to overcharging seniors for protection products. That has changed. Today when we're working with the State Departments, there's much more focus, State by State, on rate stability. Meaning, make sure you're charging appropriate rates for this type of coverage over the long term. Commissioner Dilweg, I think, addressed the rate stability component of that.

The training requirements, and one of the things that's suggested in the bill, which we support, again, expansion of the NAIC

model regulations, as well as the Partnership plans. Partnership plans, typically, at the State level, come with additional training requirements for our agents.

So, when we introduce a Partnership plan into a State, the agents typically have another 4 to 8 hours of training, and they understand, then that training requires them to understand the intersection of Medicaid, Medicare, and long-term care in the private market.

So, again, the expansion of those training programs, we think, is a good thing, as well as the adoption of the model regulation and the Partnership Program. Again, from a rate stability perspective, our focus today, very much, is on future rate stability.

The increases, perhaps, that Bonnie mentioned—one of the things that I'd like to point out is from an insurance company's perspective, if I'm forced to raise rates 30, 40, 50 percent, it's very difficult for me to stay in the market. I think you'll find that most of the insurers that are selling products today are not in that category of doubling rates on their insured block.

This is a relatively young product, it's only been around for 35 years. There was a sorting out, a number of carriers have left the market. Those who are actively selling a product today are not interested in raising rates on their consumers.

The CHAIRMAN. Ms. Burns.

Ms. BURNS. I wanted to speak to the issue of the Partnership for a moment, because we had our experience with that program in California early on, as one of the four original States, and we saw a lot of marketing issues around that product until we imposed some pretty serious training requirements.

The NAIC model training requirements are half of what we require in California. We require an 8-hour training on long-term care first, and another 8 hours for Partnership, because we think that the combination of a private commercial product with a State's public benefits program is a pretty serious issue, and needs to be carefully explained to consumers. The documents that agents use need to be drafted by the States' Medicaid program and not documents that agents and companies design themselves.

That is one of my concerns about the expansion of the Partnership Program across the States. There's not a lot of consistency between the States about how information about the State Medicaid Program is being handled. I think that promises are being made in the Partnership States that are never going to be kept, because the agents themselves don't understand the integration between a commercial product and the State Medicaid program. They don't understand, how those programs work, so they're not able to explain them well to the people that they're selling insurance to.

Another issue is people who live in an area that borders another State. Agents may be selling in both States with a Medicaid program that is different in each State. As you know, Medicaid is not consistent across the country, it's different in every single State. Our concern is how that's being explained to consumers and what they will know about how Medicaid works in their own State, and what they will know if they move to another State, where Medicaid may be different.

Having asset protection through a Partnership Program does not mean that you will not have to meet the eligibility requirements in the State that you live in when you apply for Medicaid.

Many people are misled about how the eligibility for a State Medicaid program interacts with asset protection.

The CHAIRMAN. Yes, anybody else on that issue?

Yes, Ms. Cutter?

Ms. CUTTER. Yes, Senator. I would just like to reinforce a little bit of what Bonnie had said about training. I think you'll find that in the four original Partnership States, we have been extremely serious in terms of agent training. We have, first of all, you have to go to 40 hours of classroom training in Indiana in order to get an insurance license, at all, to sell accident and health products.

In addition to that, we have an 8-hour requirement for long-term care, an additional seven hours for Partnership, specifically. Every two years, that individual has to have five hours for Partnership long-term care, specifically. We don't authorize agents out of State to sell Partnership products to anybody in Indiana. You have to live in Indiana and come to Indiana and be a resident of Indiana to sell Partnership products in Indiana.

I would assert that our agent training in that regard, and the communication that those agents take very seriously with their consumers—if the DRA, Deficit Reduction Act—which is expanding the Partnership products in the other States.

As long as they maintain similar standards, I think, to the original four states, I think those communication issues—to Bonnie's point—you know, when there some disclosure processes that are standardized, would be helpful.

We do not allow any agent to deliver any long-term care advertising material that we haven't approved at our Department of Insurance.

The CHAIRMAN. Another question for you, Ms. Burns.

In your testimony you said that no specific roadmap exists to help patients and caregivers navigate the challenges of long-term care insurance. In your judgment, would a website that provided comprehensive information about policies and their features be useful to consumers and organizations like yours?

Ms. BURNS. I think such a website would, help people navigate the long-term care system in a State, as well as help them to sort out some of the differences between long-term care insurance products.

The CHAIRMAN. OK.

Any other comments on this subject? It's been very illuminating hearing, you all have provided a lot of information. Mr. Stinson, go ahead?

Mr. STINSON. Yes, Senator, just building on your "Compare" website, the idea in the bill, which I think is great. You know, Bonnie mentioned, some companies do it right, some companies may not. We wholeheartedly endorse transparency. I think putting information out there about claims-paying ability, and our claims history, and rate stability and those things, I think, is a good thing for consumers. I think it would give them an air of confidence, I think it would instill more of a practiced approach to thinking about senior planning, as opposed to just wading in, and having a

lot of the anecdotal information that you find in the press, and then scaring people away from even thinking about it.

So, I think the suggestions in the bill, and the proposals, are very solid, in terms of having that transparency available for consumers.

The CHAIRMAN. Yes, Dr. Rowland?

Dr. ROWLAND. Senator, I would also say that I know Senator Wyden was very involved in helping to get the standards set for Medigap policies, and for the marketing of Medigap policies. I think one of the instructive ways one could look at this is to look at, the standardization of some of the choices one has around Medigap now, and the way in which that has worked to help consumers to make more informed choice based on things other than just price. Medigap regulation's would be a good example to continue to look at, especially, in developing a website.

The CHAIRMAN. Thank you, yes. I agree with that.

Well, thank you all for being here today, you'd shed a lot of light on a very important topic, and thank you for your time in imparting your knowledge to us.

Thank you so much.

[Whereupon, at 3:12 p.m., the hearing was adjourned.]

A P P E N D I X

SEAN DILWEG RESPONSES TO SENATOR MEL MARTINEZ QUESTIONS

Question 1. What percentage of seniors in your state would need to have long-term care insurance to make a substantial impact on state long-term care financing? Do you support increasing the number of seniors with long-term care insurance? If so, how do you propose increasing the number of seniors with long-term care insurance to reach that threshold?

Answer. We could not find an analysis of the number of long-term care insurance policies that would be needed in Wisconsin in order to have a substantial impact on state long-term care financing.

I am not opposed in an increasing number of long-term care insurance policyholders in Wisconsin so long as the policies are sold in a proper manner and are suitable, affordable and meet the needs of the individuals who purchased them. As I stated in my testimony, long-term care insurance should only be purchased as part of an overall financial plan where the person's financial situation is thoroughly assessed and all options in funding a person's long-term care needs are considered.

Question 2. What does Wisconsin see as the primary barriers to seniors for purchasing long-term care insurance?

Answer. The cost for long-term care insurance can be substantial, especially if it is purchased at older ages.

Question 3. The Kaiser Family Foundation report on long-term care insurance found that premium cost is the biggest obstacle to purchasing long-term care insurance, how do you propose lowering the cost of premiums so that more people buy long-term care insurance?

Answer. I do not see an insurance regulator's role as lowering premium, if the premium accurately reflects the expected cost and especially if the lowered premium result in unsuitable sale and adverse solvency issues for the market. The premiums charged with any insurance product should reflect the risk that is being assumed by the insurer. The greater and higher cost of the risk, the greater the premium to the policyholders to spread that risk and cost. People who cannot afford to pay the cost of long-term care insurance premiums should not purchase the coverage in the first place. A properly rated long-term care insurance product has what I believe to be a built-in suitability standard; the cost of the premium. The problem comes when an under priced product is sold that needs a substantial rate increase after it is sold. There will likely be many people who bought the product at its initial price who can no longer afford the policy at its new price. The current NAIC model attempts to address this problem by requiring the insurance company's actuary to certify that the rates have been developed so that they will not increase over the life of policy under moderately adverse conditions.

Question 4. Has the state of Wisconsin adopted the National Association of Insurance Commissioners (NAIC) most recent model law and all updates? Are there any NAIC recommendations, provisions, updates, rules, models, or other language that the state of Wisconsin has declined or failed to adopt? If so, why?

Answer. Yes. We have incorporated all of the NAIC's long-term care insurance model provisions in our regulations. We have made a few changes to the NAIC provisions in our law that we believe have resulted in stronger consumer protections.

Question 5. Is there empirical evidence to show that the NAIC long-term care insurance Model, which has been adopted by several states, has actually held long-term care insurance rates down or leveled them off?

Answer. I am not aware of any such data or study. It is important to note that most of the premium rate increases we are experiencing today are from policies that were issued prior to any rate stability provisions in the NAIC model.

Question 6. Does this Model allow states to continue with their own actuarial reviews using the current 60% loss ratio standard?

Answer. Since the rate stability provisions contained in the current model are only advisory, states are free to use any standard in performing their rate reviews. The NAIC model contemplates no loss ratio at the initial filing. However, if rates are increased and the increase is not an exceptional increase, then the premiums collected prior to the rate increase must meet a 58% loss ratio test and any premium collected under the increased rates must meet an 85% loss ratio test.

Question 7. Does the NAIC know that each and every state currently conducts an actuarial review of all long-term care insurance rates before approval?

Answer. I am not aware that the NAIC has information that indicates all states conduct actuarial reviews of all long-term insurance rates before approval.

Question 8. Does this long-term care insurance Model regulation allow states to examine long-term care insurance rates for future assumptive driven actuarial data?

Answer. I am not familiar with the term “future assumptive driven actuarial data.” In any event, the Model does not prohibit a state from reviewing any data in connection with a long-term care insurance rate filing.

Question 9. If so, does the regulation allow states to disregard those assumptions?

Answer. Not applicable.

Question 10. How does the “exceptional” increase standard protect consumers from future rate increases?

Answer. The theory behind the current premium rate stabilization standards contained in the NAIC model is putting the company on record through an actuarial certification that the premium rates were developed so that there would not be a need for a rate increase over the life of the policy under moderately adverse conditions. This certification process was designed so that long-term care insurers would properly price their products at their introduction. Unless the company can demonstrate that a rate increase is needed as result of exceptional circumstances, a state can take punitive action on that company for the rate increase filing as outlined in the model.

Question 11. What changes need to be made to this long-term care insurance Model to better provide consumer protections for both policy contract requirements and rates?

Answer. I think we need to closely monitor the effect of the current rate stabilization provisions on rate filings. If we get a high number of rate filings under these provisions, they will need to be modified in order to achieve the stability in long-term care premium costs that we all want to see. We also need to determine whether minimum, best practice standards need to be developed for claims handling. Long-term care insurers are becoming increasingly more active in developing, implementing and monitoring a plan of care for their policyholders on claim. Insurers assist their policyholders in finding long-term care services and making sure that their claims are being properly handled. This results in an inherent conflict between claim levels and profits. We need to monitor the evolution of these practices and be prepared to codify minimum standards in order to protect those claimants from unscrupulous claim handling activity.

Question 12. How do you see the increased group market for long-term care insurance affecting consumers?

Answer. The group long-term care insurance market segment is the fastest growing segment of the market. This is primarily in the employer group market where the employer offers long-term care insurance coverage to its employees, dependents and, in some cases, family members such as parents. In most of these circumstances, it is my understanding that the employer does not contribute to the premium for long-term care insurance, it merely provides a facility for employees to purchase the coverage. I see this positively. Employers will usually screen coverage they are making available to their employees quite closely to ensure that it is meaningful coverage from a reputable carrier. In addition, there may be a premium break in group policies on premise that administration costs are lower for the insurer, thus reducing the premium to the customer.

Question 13. Over the next 20 years, the number of Americans over 65 years old with Alzheimer’s will increase by more than 50 percent. Because Alzheimer’s is one of the few diseases requiring 24 hour care, how do you see the increased prevalence of this disease affecting long-term care insurance companies?

Answer. Long-term care insurance policies are currently prohibited from excluding Alzheimer’s disease from coverage. I assume that insurers have access to the same information we all do concerning the expected prevalence of the disease into the future and would include this as a factor in setting their premium rates. For those companies who fail to account for a factor such as this may run into financial trouble if they underestimated the cost in rate setting. Premium costs to policyholders could likely go up.

Question 14. How does the state of Wisconsin coordinate the state Medicaid office and state insurance commissioner's office with the long-term care insurance company when a Partnership policyholder exhausts his policy's benefits?

Answer. We do not coordinate with the State Medicaid office when a Partnership policyholder exhausts his policy's benefits. We have coordinated and will continue to coordinate with the State Medicaid office with respect to Partnership policy form approval and agent training standards and implementation. When a Partnership policyholder exhausts the benefits under the policy, the long-term care insurer is required to provide the policyholder with a statement indicating the amount of claim payments made under the policy as proof of asset protection when the person applies for Medicaid eligibility. That is a transaction between the person and the State Medicaid office. My office does not have a role in that transaction except if the consumer is having difficulty securing the statement from the insurer verifying the amount of claims paid under the policy.

CAROL CUTTER RESPONSES TO SENATOR MEL MARTINEZ QUESTIONS

Question 1. Has the state of Indiana adopted the National Association of Insurance Commissioners (NAIC) most recent model law and any updates? Are there any NAIC recommendations, provisions, updates, rules, models, or other language that the state of Indiana has declined or failed to adopt? If so, why?

Answer. Indiana has not adopted the most recent model law for LTC that was updated in 2006. Indiana's primary concern with that model is the 'rate stabilization requirement contained in that update. It is the considered opinion of our actuaries that the language in this model prohibits the Department from applying the same scrutiny and control over requested rate increases that we currently have.

Question 2. Is there empirical evidence to show that the NAIC long-term care insurance Model, which has been adopted by several states, has actually held long-term care insurance rates down or leveled them off?

Answer. Not that has been presented to our satisfaction. Actually we have comments from several other states' actuaries questioning the effectiveness of the rate stabilization feature of the model that those states have adopted.

Question 3. Does this Model allow states to continue with their own actuarial reviews using the current 60% loss ratio standard?

Answer. There is a difference of opinion among the states who have adopted this model, on this issue. Some actuaries have said 'no, the state cannot', and other have said 'we're not sure, but we intend to continue with the 60% until advised to the contrary'. Indiana's opinion is that we cannot until the loss ratio meets or exceeds the 70% 'exceptional' level as described in the model.

Question 4. Does the NAIC know that each and every state currently conducts an actuarial review of all long-term care insurance rates before approval?

Answer. We don't believe that the NAIC can answer with any certainty whether each and every state does conduct an actuarial review. Many states don't require filing of rates and forms at all, so our conclusion is that there must be numerous states that don't or can't conduct an actuarial review.

Question 5. Does this long-term care insurance Model regulation allow states to examine long-term care insurance rates for future assumptive driven actuarial data?

Answer. Not in our opinion. From the language in the model, it appears that all the insurer must do, once reaching the 70% exceptional loss ratio, is to attest that they have met the requirements of the model and are applying rate increases as allowed under that provision.

Question 6. If so, does the regulation allow states to disregard those assumptions?

Answer. We cannot find any language allowing states to disregard those assumptions.

Question 7. How does the 'exceptional' increase standard protect consumers from future rate increases?

Answer. In our opinion it does not protect consumers from future rate increases.

Question 8. What changes need to be made to this long-term care insurance Model to better provide consumer protections for both policy contract requirements and rates?

Answer. For contract forms, some type of standardization might be acceptable. Tighter standards for rate increases based on non-assumptive actuarial presentations, with some at least annual percentage cap that the carrier could impose—say 40% as an example, in any one year.

Question 9. What sort of federal requirements do you recommend to help state insurance commissioners negotiate the best rates for policyholders?

Answer. Since insurers predicate their rate structures on their own in-force blocks of business, the experience of those blocks as well as the market place for LTC in general, it would be difficult to suggest any federal laws or regulations that would not handcuff the insurers and ultimately eliminate the LTC market altogether.

Question 10. What percentage of seniors in your state would need to have long-term care insurance to make a substantial impact on state long-term care financing? Do you support increasing the number of seniors with long-term care insurance? If so, how do you propose increasing the number of seniors with long-term care insurance to reach that threshold?

Answer. Even 40% would make a difference of millions of dollars in protecting our citizens from self-imposed impoverishment and Medicaid funds that need to be available for the truly poor population of our state. We do support increasing the number of seniors with LTC protection and are preparing a massive awareness campaign that begins this fall, to initiate that awareness.

Question 11. What does Wisconsin see as the primary barriers to seniors for purchasing long-term care insurance?

Answer. Indiana can't speak for Wisconsin.

Question 12. The Kaiser Family Foundation report on long-term care insurance found that premium cost is the biggest obstacle to purchasing long-term care insurance, how do you propose lowering the cost of premiums so that more people buy long-term care insurance?

Answer. Cost can be addressed through more flexible benefit designs, shorter benefit durations (one year versus lifetime), and other coverage-based improvements. Group plans will also be more affordable than individual plans.

Question 13. How do you see the increased group market for long-term care insurance affecting consumers?

Answer. The group market will help tremendously in improving LTC coverage, because it will be offered through the employer market and typically be sold on a 'guarantee issue' basis rather than having to meet a variety of medical questions for approval. It also allows employees to cover parents and/or grandparents who are currently insured, all at group rates.

Question 14. Over the next 20 years, the number of Americans over 65 years old with Alzheimer's will increase by more than 50 percent. Because Alzheimer's is one of the few diseases requiring 24 hour care, how do you see the increased prevalence of this disease affecting long-term care insurance companies?

Answer. This is where the assisted-living and home care benefits can be most helpful. Most Alzheimer's patients that I've been in personal contact with are mobile, able to bathe, toilet, and generally feed themselves with some reminders or assistance. This means total 24 hour facility care, especially with some of the pharmaceutical advances in treating this disease, will be less necessary.

Question 15. How does the state of Indiana coordinate the state Medicaid office and state insurance commissioner's office with the long-term care insurance company when a Partnership policyholder exhausts his policy's benefits?

Answer. Indiana's Medicaid office has a designated recovery agent that works with our Partnership division even before the policy has completely exhausted, so that there is already a plan in place for the policyholder once exhaustion occurs.

Question 16. Why should or shouldn't Congress enact more federal requirements for the long-term care partnership program?

Answer. The most likely are that Congress can affect in LTC policies that would be beneficial to potential purchasers, agents, and companies alike would be to 'standardize' the benefit plans as has been done with Medicare Supplements.



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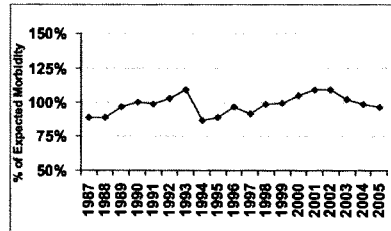
Chairman Herb Kohl
330 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Kohl,

I appreciated the opportunity to address the Special Committee on Aging on behalf of Genworth and the broader Long Term Care insurance industry. During last week's hearing, you asked whether or not long-term care risk is an insurable event or one that might be better suited to a different funding structure. While I gave a brief answer, I would like to take this opportunity to provide the committee with additional information.

There are two important characteristics when defining an insurable risk: [1] the ability to manage the various contingencies by pooling several individual risks together, and [2] the ability to adequately and systematically pre-fund the end costs with a high degree of statistical confidence. Given these definitions, long term care is insurable.

In the early days of our industry, it was thought that the long term care risk, or more accurately the *morbidity* risk, would be extremely volatile. Since then, we have learned that this risk is not nearly as unpredictable as many of the other insurance risks commonly addressed by insurance models. The chart on the right demonstrates that over the 20-year period from 1986 through 2005, Genworth's morbidity experience was relatively flat and the standard deviation was less than 5%. Although not fully complete, the experience between 2006 and 2008 has remained generally consistent with this data. The chart also shows that we have been able to predict expected values with a high degree of confidence from the pooling of large numbers of individual risks.



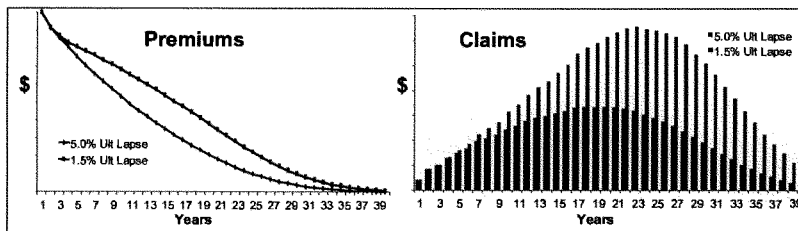
Certain companies have been criticized for raising their premium rates on inforce policies, which might indicate that morbidity risk cannot be predicted with any measure of certainty. It's important to point out that there are other factors that influence the long term care insurance liability. One important variable in the liability equation is the assumption of how many policyholders will voluntarily stop paying premium and lapse their policies.

When the long term care insurance product was originally introduced in the 70's, it was necessary to make best-guess estimates for many of the contingencies for which there was



limited data. Chief among those risks was persistency – the risk that policyholders would voluntarily lapse the coverage sometime in the future. Understanding the size of the risk pool is critical to understanding the total amount of claims that will ultimately be paid out. Most carriers assumed that long term care persistency would follow the experience of its closest cousin, i.e. disability insurance, for which there was ample data and a general expectation that between 5-10% of policyholders per year would lapse their coverage. We have found that the voluntary lapse rate to be closer to 1.5% each year.

This is demonstrated graphically in the two charts below. On the left, there is a comparison of the differences in collected premium when a 1.5% lapse rate is assumed versus a 5% rate. More premium is collected where fewer policyholders lapse. On the right is the comparison of the ensuing claims. It is fairly clear from these charts that not enough additional premiums will be collected to offset the additional claims stemming from the differences in lapsation. The gap is what led to many of the rate increases in our industry.

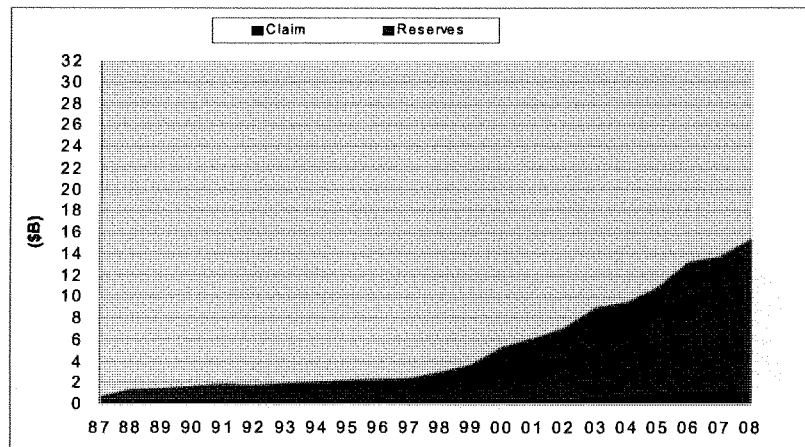


The difference resulted from incorrect predictions of the mean, rather than the failure of the industry to accurately manage the volatility of the lapsation variable. However, with the benefit of over 35 years of experience, including millions of exposure years and some 130,000 individual claims amounting to over \$6 billion of inception-to-date paid benefits, we now know that not only is the lapse variable highly predictable, but it has very low volatility as well.

The second characteristic that I identified of an insurable risk is the ability to confidently pre-fund the risk with statistically derived premiums. This has been one of the hallmarks of our industry from its inception.



The picture below depicts the pre-funding of reserves held against the payment of future claims and shows our past claims for our Genworth business. As you can see, an enormous reserve exceeding \$14 billion has already emerged. By December 2018, assuming we never sold another contract, this reserve would have continued to grow with investment of



collected premiums and interest earnings, continued to pay benefits (which would by then approach \$20 billion, inception-to-date) and would have more than doubled in size to exceed \$28 billion. This reserve ensures that claimants who may not file for benefits for 40 or 50 years into the future will be financed by this insurance model. I would also point out that in many cases, for the middle-class policyholder, this private long term care financing mechanism will protect the family from spending down personal resources and "tipping over" into the Medicaid system.

Based on the information provided, we believe that not only is long term care an insurable event, but that the private long term care insurance industry will continue to play an important role in our nation's overall long term care strategy.

Thank you once again for the opportunity to address the committee. I look forward to speaking with you in the future.

Sincerely yours,

Buck Stinson
President of Insurance Products
Genworth Financial



333 Summit Street
Toledo, OH 43604

June 3, 2009

Hon. Herb Kohl
Chairman
Special Committee on Aging
United States Senate
G31 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Kohl:

I would like to compliment you and the Committee members for conducting your hearing today on the value of long-term care insurance. At HCR ManorCare we are the country's largest post-acute provider serving our nation's citizens with programs in skilled nursing, assisted living, hospice care, home health services, and specialized rehabilitation and Alzheimer's care. On a daily basis we provide care to over 50,000 individuals in 34 states. We have a strong interest in ensuring that our country has an efficient, viable and economically vibrant program for long-term care for our nation's elderly.

The area of long-term insurance is critical in our nation's efforts to reform health care and ensure that there is adequate funding to meet the needs of a growing and graying population. The extremely heavy reliance on public funding for many of the country's long-term care services is placing a pressing burden on individuals, families and governments. Rising demand for services in the face of limited funding necessitates new and innovative approaches.

Funding today for nursing home care is principally provided by federal Medicare and state and federal Medicaid programs. To a limited extent private funds support facility-based long-term care services. These are essentially the same programs that have been in operation providing funding for skilled nursing since their inception in the late 1960s. I first served as a nursing home Administrator in 1972 in Pennsylvania at a time when nursing homes were places of last resort for many elderly and where the average length of stay was well over three years – with few if any active discharges back to the community. At that time there were few options for care, far too little in terms of government support and a health care system that wholly and completely relied on the physician and the acute care hospital. The system was indeed institutionally-biased.

Since that time in the late 60s and early 70s, the post-acute sector has significantly evolved and no segment more than nursing homes. I have personally witnessed a remarkable transition over these past four decades. Throughout this period our patients have changed materially from long-term chronic care to short-term high-acuity rehab and medically complex patients. Staffing, buildings, services and amenities have changed as well -- and are particularly evident in the new and renovated centers that we develop each year in our Company through our annualized capital spending of over \$100 million. Our buildings today look and act in many respects like acute care hospitals of the 1990s or inpatient rehabilitation facilities of today.

The reason I bring forward this perspective is to illustrate that as it relates to nursing homes in particular, much has changed in terms of the way we provide care and in the type of patient receiving care in our centers. As our products and patients have evolved so too have funding mechanisms from flat per diems, to cost-based reimbursement, to payments based on the acuity levels of care. Correspondingly, the sources of revenue have evolved.

I have also witnessed the evolution of the long-term care insurance market which saw particular attention by the public and subsequent growth in the mid-1990s. For a period the compound annual growth rate for insurance policies approached 20% as many people in the country realized the graying of America and the commensurate concern about how people were to receive care. Long-term care insurance policies were a creative way to help individuals prepare for catastrophic illness and the marketing of policies was to some extent driven by fears that annual costs of nursing home care totaling \$75,000 would drain whatever resources people had at their disposal. Unfortunately, this type of approach was not a proxy for the way we are in fact caring for people in nursing homes today.

To illustrate -- from that 39 month average length of stay in 1972, the average has dropped significantly to less than 80 days today. More importantly, over 65% of our discharges on an annual basis occur in less than 40 days -- with the vast majority returning home. Indeed 50% of those discharges during a given year stay less than 30 days due to better care planning and a recognition that people wish to resume their lives and live at home versus any institution.

In my first position at a large Pennsylvania nursing home, we could maintain 100% occupancy with less than 140 admissions a year. With today's difference in length of stay, that same center would need over 2,000 admissions per year to maintain a comparable occupancy. At HCR ManorCare, we operate at a very high occupancy level, which combined with a shortened length of stay, has enabled us to provide essential post-acute rehabilitation and medical services to tens of thousands more individuals during the course of a year than had we continued to function principally as a chronic care provider. Many nursing homes across the country are achieving the same results.

The point of providing this explanation on how the skilled nursing sector works is to note that the world in which long-term care insurance became initially available is entirely different than the world as it exists today. In the 1970s, less than half of our admissions were from hospitals -- most of our admissions in fact coming to us from the community. Today, over 95% of our admissions come to us directly from the hospital. These are patients whose length of stay in the acute care setting is less than five days and who have recovered from a significant event such as a cardiac episode, stroke or broken hip and for whom the acute care hospital is an inappropriate provider of post-acute care.

Today's nursing home has greater medical direction and involvement either through physicians or physician extenders together with a full array of licensed nursing personnel and other professionals. The technology that previously existed in a hospital or specialized medical facility – the therapists, technicians, pharmacists and caregivers – have migrated to the lower cost setting of a nursing home in an approach that permits higher-acuity patients to receive care, achieve beneficial outcomes and return home at lower cost to the overall health care system. Our centers have large therapy gyms, large staffs providing needed therapies, state-of-the-art equipment, access to amenities and supportive personnel and most importantly, a clear and articulate plan to get better and as noted above, return to the community.

Given this operating model where the vast majority enter nursing homes from the hospital following a traumatic incident and who will stay on average a fairly short period of time, the present long-term care insurance policy becomes of limited benefit for the insured party – as it relates to nursing home care. Virtually all of those admitted from the hospital will be eligible for payment under the Medicare program. They will in effect have very limited opportunities to utilize the policies which typically have a restriction that they do not go into effect until after other benefits (such as Medicare) have been exhausted. In our Company, we admit approximately 160,000 people a year into our nursing homes and discharge 160,000 – with as noted above 66% in roughly less than 40 days. Therefore, the probabilities of needing care beyond that time are very small -- and for many of those individuals, they would have significantly limited means by which to purchase long-term care insurance. Indeed at today's rates, many of these policies are prohibitive for the average person.

Without question there are some patients within nursing homes (although very limited) whose needs require longer stays, however, as noted, many of these would have limited means by which to acquire long-term care insurance.

I have long believed that our entire system of care would be better served if indeed we would incentivize individuals to purchase long-term care insurance that sits in front of the Medicare skilled nursing benefit. This is similar to the way in which care is provided to kidney dialysis where private insurance must first be exhausted before the long-term Medicare benefit commences. This would serve several purposes. First, this type of insurance would be much more cost effective, given that it would only need to cover the first 20-30 days of care. At current Medicare payment levels this would require coverage for approximately \$8,000 - \$12,000 – a cost that would require minimal levels of payment compared to today's charges for a standard long-term care policy.

Secondly, given the lower cost, more individuals would consider purchasing these policies with the understanding that Medicare would step in for any periods of care extending beyond this insured period. With more individuals purchasing insurance at lower coverage limits the cost of insurance would hopefully decrease – although I am admittedly not an insurance expert.

There are recognizably several problems with this approach. First, it does not create coverage for other levels of care such as home health or assisted living – but if much of the premium for current policies is driven by the high cost of nursing home care then I am relatively certain that the home care benefit and other components would represent a limited

add-on to this type of policy. Actuaries could determine this but only if they truly understand the model of operation for today's providers.

One final point that I would like to make is that policy makers at the federal level appear to me to also believe that because Medicaid patient days are so high in nursing homes that this portends a story of medically indigent individuals representing the vast bulk of our patients and draining state coffers. This is simply not true. In our Company, Medicaid patients take up 45% of our patient days (on which we lose approximately \$25/day due to inadequate state reimbursements). Due to the fact that states pay so poorly for their care, the revenues from this patient day base are roughly 24% of our total revenues. More importantly, of the volume of patients within the 45% of patient days noted above, they represent a mere 13% of the total number of individuals served in our skilled nursing centers on an annual basis. This is due to the high volumes of shorter-term patients that receive care during far shorter durations than the chronic care population. We provide complex medical and rehabilitative care to hundreds of thousands of individuals – far more than the medically indigent. My experience leads me to a conclusion that policy makers should take the time to visit today's modern nursing home and speak directly with the people who represent this segment of the health care system. I would gladly provide that experience to any individuals on your staff. It is also why long-term care insurance simply does not work today for nursing home care as the insurance industry is looking at the few patients that stay for an extended time versus the many that stay for a very short period.

In summary, I support and applaud your efforts to look at ways to help make long-term care insurance more viable. Inasmuch as it represents only 1% of our revenues in the skilled, assisted and home care segments of our business, it clearly is not working to help consumers pay for these services. Long-term care insurance policies may, as I point out above, serve to hold some answer to the rising health care costs and the need to stretch the public Medicare and Medicaid dollar.

If I can be of any assistance to you or your staff on this topic, please do not hesitate to contact me.

Sincerely,



Stephen L. Guiffard
Executive Vice President
Chief Operating Officer